Supreme Court, U.S.
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No. _____

In the Supreme Court of the United States

October Term, 1995

PATRICK BOYLE, JAMES DAUGHERTY, P. DAN GILBERT, LARRY JORDAN, CHARLES MALONEY, THOMAS MARTIN, ROBERT SCHWARTZBAUER, and GARY THADEN, as the Board of Trustees of the Twin City Pipe Trades Welfare Trust, et al.,

Petitioners,

vs.

MATTHEW G. SMITH, in his capacity as the Commissioner of the Minnesota Department of Revenue, et al.,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

William A. Cumming (#175067)
Lee A. Henderson (#126305)
Hessian, McKasy & Soderberg, P.A.
4700 IDS Center
80 South Eighth Street
Minneapolis, Minnesota 55402-2228
(612) 330-3000

January 15, 1996 *Attorneys for Petitioners*

1996 – Bachman Legal Printing ■ (612) 339-9518 ■ FAX (612) 337-8053

141 pp

QUESTIONS PRESENTED

A. Should the Court grant certiorari to review the United States Court of Appeals for the Eighth Circuit's decision that the two percent tax imposed on Minnesota health care providers that is effectively passed on to self-funded health plans neither directly relates to ERISA plans nor has a sufficient enough impact on such plans to invoke ERISA preemption via the Supremacy Clause of the United States Constitution?

B. Should the Court grant certiorari to review the United States Court of Appeals for the Eighth Circuit's decision that Petitioners did not meet the Constitutional requirements for Article III standing under the United States Constitution to challenge an already enacted and effective statute promulgated by the Minnesota legislature that mandates self-funded health plans to collect and report data on the basis that ERISA, via the Supremacy Clause of the United States Constitution, preempted such regulation by the Minnesota legislature?

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No. _____

In the
Supreme Court of the United States
October Term, 1995

PATRICK BOYLE, JAMES DAUGHERTY, P. DAN GILBERT, LARRY JORDAN, CHARLES MALONEY, THOMAS MARTIN, ROBERT SCHWARTZBAUER, and GARY THADEN, as the Board of Trustees of the Twin City Pipe Trades Welfare Trust, et al.,

Petitioners,

vs.

MATTHEW G. SMITH, in his capacity as the Commissioner of the Minnesota Department of Revenue, et al.,

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PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

TO: THE HONORABLE CHIEF JUSTICE AND THE ASSOCIATE JUSTICES OF THE UNITED STATES SUPREME COURT.

Petitioners, Patrick Boyle, et al., respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit entered on October 18, 1995 in this matter.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 68 F.3d 1093 (8th Cir. 1995) and was filed on October 18, 1995. The District Court's opinion is reported at 849 F. Supp. 1307 (D. Minn. 1994) and was decided on April 12, 1994. Both opinions are set forth in the attached Appendix.

JURISDICTION

The judgment of the Court of Appeals was entered on October 18, 1995, and this petition has been filed within ninety (90) days. This Court's jurisdiction to consider this petition from the judgment or decree of the United States Court of Appeals for the Eighth Circuit is invoked pursuant to 28 U.S.C. § 1254.

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS

The following are the provisions which are involved in this case: U.S. Const. Art. III and VI; 29 U.S.C. § 1144; Minn. Stat. §§ 62J.04, 62J.35, 62J.38, 62J.42, 62J.45, 295.52, 295.53, 295.582 (1994); and Minnesota Rules 4652.0110. The relevant portions involved are printed in the Appendix.

STATEMENT OF THE CASE

In 1992, the Minnesota legislature passed and enacted significant legislation related to the provision of health care benefits in Minnesota, initially known as the HealthRight Law ("HealthRight"), the legislation addressed a number of noble issues including the establishment of a health care program for Minnesotans who could not afford health insurance. A year later, in an attempt to further the administrative, financing and

policy goals of HealthRight, the Minnesota legislature passed several significant amendments to the statute and the health care program became known throughout Minnesota as well as across the country as MinnesotaCare, ("MinnesotaCare").

Rather than finance this broad-based health care program for Minnesota's uninsured residents through a general tax, the legislature imposed an assessment or tax upon hospitals and health care providers through Minn. Stat. § 295.52. The initial tax was set at two percent of gross revenues of the health care providers ("Provider Tax"). The relationship of this tax to ERISA governed plans is apparent in the portion of MinnesotaCare which relates to the authority for hospitals to directly pass through the Provider Tax imposed by MinnesotaCare to third party payers. The statute provides that "all third party purchasers of health care services including, but not limited to, third party purchasers regulated under Chapters 60A, 62A, 62C, 62D, 64B, or 62H, must pay the transferred expense in addition to any payments due under existing or future contracts with the hospital or health care provider to the extent allowed under federal law." Minn. Stat. § 295.582.(1994). The Petitioners are third party purchasers of health benefits because the plans pay hospital and doctor benefits on behalf of their members. Accordingly, the provisions of MinnesotaCare apply directly to Petitioners and the Provider Tax has a direct and substantial impact on both the providers and ERISA plans.

In addition to imposing the Provider Tax, MinnesotaCare directly imposes two other forms of regulation on the appellants. First, the plans are required to collect and report data on health care spending by various categories, as well as on administrative expenses and reserves in a format specified by the state. Minn. Stat. § 62J.38.(1994). Additionally, the state has imposed caps on increased health care spending for health plans and group purchasers, which include the Petitioners' plans and trusts. Minn. Stat. § 62J.04.(1994).

The reporting obligations mandated by the Minnesota Legislature directly regulate Petitioners' plans by identifying the type of plans which the state intends to regulate and imposing significant and direct administrative burdens upon the plans to the extent that they attempt to comply with the requirements.

REASONS FOR GRANTING THE WRIT

I. Introduction

Petitioners cannot sufficiently underscore the need for this Court to provide further clarification with respect to the numerous and inconsistent appellate court decisions relating to ERISA preemption in the context of a statute's economic impact upon ERISA regulated self-funded health plans. The decision below opens the door to virtually unlimited state taxation of self-funded health plans under the guise of "indirect" regulation.

This Petition for Writ of Certiorari is also of paramount importance with respect to clarifying the Article III requirements for justiciability as well as the intimate relationship and interplay between the standing and ripeness doctrines as applied to already enacted but not yet enforced statutes. The circuits are in conflict on this issue and the Eighth Circuit ignored this Court's decision in *Babbitt v. United Farm Workers Nat'l Union, 422 U.S. 289 (1979).*

Accordingly, Petitioners pray that this Court give careful consideration to the substantive issues raised in this Petition as well as to the need for clarification and pronouncement from this Court with respect to the conflict and confusion that exists among the Circuits.

II. Minnesota's Provider Tax Should Be Subject To ERISA Preemption Because It Constitutes Regulation Of Employee Benefit Plans

Petitioners respectfully contend that the Eighth Circuit's decision below should be reversed because it establishes a dangerous precedent in allowing states to subvert the intentions of the United States Congress by regulating ERISA based plans through a scheme of veiled regulation, and that it conflicts with this Court's reasoning in *New York Conf. of Blue Cross v. Travelers Ins. Co.*,___ U.S.___, 131 L.Ed 2d 695, 115, S.Ct. 1671, 1995 U.S. LEXIS 3038 (1995).

It is the former concern which should be of the utmost importance to this Court and was keenly envisioned by Justice Souter's opinion in *Travelers*. Should the Court allow the Eighth Circuit opinion to go unreviewed, states will now have the license to regulate ERISA plans by avoiding direct regulation and attempting to regulate employee benefit plans indirectly. Such a result is not what Congress intended. Therefore, the Court should grant the writ.

A. The Minnesota Provider Tax conflicts with the provisions of ERISA's preemption clause and the policy supporting that statutory provision.

The provider tax utilized by Minnesota should be subject to preemption because the tax represents regulation by the state of self-funded ERISA health plans. A tax that was levied directly against self-funded ERISA regulated plans by state statute would unarguably be subject to ERISA preemption. For instance, if the state recited in its tax statute that self-funded employee benefit plans were to be subject to a two percent tax on health care dollars spent at Minnesota hospitals and with Minnesota health care providers, ERISA preemption would certainly apply to this direct regulation. ERISA

preempts the direct regulation by the states of employee benefit plans, with the exception of those regulations which deal with the business of insurance, and further provides that self-funded health plans are not deemed to be in the business of insurance. 29 U.S.C. § 1144.

In the present case, all that the state legislature in Minnesota has done is look at what is plainly preempted, specifically direct regulation of employee benefit plans, and has moved that regulation one step upstream in commerce to impose the tax upon the people who receive substantially all the money paid out from the self-funded employee benefit plans within the state. In doing this, the state merely exalts form over substance, effectively doing indirectly what it could not do directly.

There has never been any question that the state intended health care providers and hospitals to pass along the tax to the ultimate payers. This is evidenced by the specific references set forth in the Minnesota State Senate hearings on the specific tax language to be used in the statute. See Affidavit of Dorine Pauly set forth in the attached Appendix. It is further evidenced by the legislature's enactment of a specific pass-through provision which mandates that the tax be paid by all third party payers when identified to them by a health care provider in conjunction with a regular health care bill. Minn. Stat. § 295.582.(1994).

The effect of allowing this one step removed taxation of employee benefit plans will have, if allowed to stand, is that a state can generate whatever revenue it deems necessary from ERISA plans if it places the assessment upon anyone in the health care industry which the plan interacts with as a part of doing its business, namely the dispensing of benefits.

The principal established by the decision of the Eighth Circuit Court of Appeals is that a state is now free to recharacterize any assessment which could not previously have been asserted against a self-funded employee benefit plan and

place that assessment into the health care industry at the layer above the plan as an assessment payable by that entity. With the use of a pass-through requirement, the tax would then ultimately be paid by the employee benefit plan.

An example of this problem is Minnesota's assessment for its Comprehensive Health Association. In the 1970's Minnesota adopted a tax which was assessed against insurers and self-insured plans on the basis of premium dollars for insurers and benefit dollars paid by employee benefit plans as a way to raise funds for a state subsidized health plan for individuals who had otherwise been denied insurance coverage. The tax was allowed to stand as to insurance companies but was preempted by the Federal District Court in Minnesota as to employee benefit plan as a form of direct regulation by the state. *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F.Supp. 931, (D. Minn. 1980).

In 1996, the Minnesota Legislature can now impose this same tax for the Minnesota Comprehensive Health Association on health care providers, instead of self-funded health plans, and enjoy the revenue because the tax can be structured exactly as the existing Minnesota provider tax. The tax can be designed with the same pass-throughs as the current provider tax and employee benefit plans would ultimately have to pay the assessment. This mechanism to regulate self-funded employee benefit plans conflicts with the undisputed purpose of ERISA preemption and should not be allowed.

B. The Decision Below is at Odds With this Court's Decision in *Travelers*.

The decision by the court of appeals in this case conflicts with the parameters for determining ERISA preemption set out by this Court in *New York Conf. of Blue Cross v. Travelers Ins. Co.*, ___ *U.S.* ___, *131 L.Ed 2d 695, 115 S.Ct. 1671, 1995 U.S. LEXIS 3038 (1995).* In *Travelers*, Justice

Souter set out a parameter to be applied to determine whether state regulations which are economic in character and which do not directly regulate an employee benefit plan are sufficient to trigger ERISA preemption. A regulation would be preempted if it has the effect of forcing a choice upon employee benefit plans. *Travelers, 1995 U.S. LEXIS at *25.* Specifically in *Travelers*, Justice Souter found that an assessment added to DRG rates in the State of New York which did not apply to Blue Cross/Blue Shield, but did apply to commercial insurers and certain other health care payers, did not result in a forced choice which triggered ERISA preemption. *Id.* Instead, Justice Souter found that the regulation merely impacted the relative cost of choices available to ERISA plans. *Id.* The surcharge applicable to commercial insurers made Blue Cross/Blue Shield potentially more competitive and if plans wish to elect a commercial insurer who is subject to the DRG assessments, that would have been a cost choice which the plan would have been free to make, but was not bound to make.

In the present case, the provider tax applies to charges which are paid by all payers of health care services other than the government sponsored health programs, such as Medicare, Medicaid and the MinnesotaCare insurance program for otherwise uninsured Minnesotans. Minn. Stat. § 295.53 (1994). Because substantially all of the remaining pool of health care consumers receive their health care benefits through ERISA plans, the groups which are required to pay the tax are ERISA plans, and there are no other exceptions to this obligation for the tax.

As a result, an employee benefit plan, specifically a self-funded ERISA regulated plan, does not have any choice to make. Unlike the ERISA plans in the State of New York which can choose between Blue Cross/Blue Shield and another commercial insurer, all services provided in Minnesota

paid for by a self-funded plan are subject to the tax and the obligation to pay that tax is mandated for all payers.

In addition to establishing the provider tax, the state further enacted a "pass-through" provision at Minn. Stat. § 295.582. The statutory pass-through provision gave authority to health care providers to specifically bill all third party payers for the provider tax and mandated that all third party payers be required to pay the tax in addition to any provider fees which would be invoiced as set out in provider contracts. The statutory provision further contemplated that providers may choose to include the tax in the amount of their billed charges as an alternative for recovering the tax. All of this reflects the legislative intent to have providers pass the tax along in one form or another, and that providers would not be absorbing the tax.

The evidence submitted in support of the employee benefit trusts in this case to the trial court reflected that hospitals, health maintenance organizations and providers would either expressly add the tax to their bills utilizing the pass-through provision, or consciously added the tax amount to billed charges so that it would be recovered from the entities which actually pay medical bills, specifically including self-funded health plans.

Applying the test set forth in *Travelers* with respect to compelling employee benefit plans to pay a certain fee or assessment, Minnesota's provider tax which requires all payers who are not government plans to pay the assessment should invoke preemption. This Court should also note that the Ninth Circuit has considered this Court's decision in *Travelers* in the context of an ERISA preemption case. *ABC National Line Erection Apprenticeship Training Trust v. Aubry*, 68 F.3d 343 (9th Cir. 1995). The *ABC* Court, however, did not follow *Travelers'* reasoning with respect to compelling prevailing wage regulation in California's apprenticeship programs. Petitioners understand that a petition for a Writ of Certiorari is

forthcoming in that case as well. Petitioners assert that a compelled choice, such as Minnesota's provider tax, should trigger ERISA's preemption provision based upon the reasoning in *Travelers*. Accordingly, review should be granted in this case to clarify the scope of ERISA's preemption clause.

III. A Duly Enacted Statute Which Threatens Injury To A Party, Although Not Yet Enforced, Confers Article III Standing On The Aggrieved Party.

Petitioners respectfully contend that the Court of Appeals below misapplied the law of standing and justiciability under Article III of the United States Constitution and misinterpreted the MinnesotaCare statute in construing whether Petitioners met the requirements for Article III standing. The precise issue presented is whether an already enacted but not yet enforced statute which threatens injury to Petitioners is sufficient to confer standing to sue. This controversy requires this Court's resolution in light of the decision by the Court of Appeals below.

A. This Court has recognized a case or controversy under Article III of the United States Constitution in similar situations where there is a credible threat of prosecution based on an enacted statute.

It is commonly known that Article III of the United States Constitution requires a "case or controversy" for a federal court to entertain a claim. A "case or controversy" is presented when "conflicting contentions of the parties . . . present a real, substantial controversy between the parties having adverse legal interests, a dispute definite and concrete, not hypothetical or abstract." *Babbitt v. United Farm*

Workers Nat'l Union, 442 U.S. 289, 298 (1979) (citation omitted). The distinction between a hypothetical or abstract question and a "case or controversy" depends upon the factual circumstances presented in each case. *Id.* at 297 (*citing Maryland Casualty Co. v. Pacific Coal & Oil Co.*, 312 U.S. 270, 273 (1941)). In the instant case, Petitioners have challenged the constitutionality of the MinnesotaCare statute with respect to the data collection and reporting requirements mandated by the statute. In this regard, this Court's prior precedent as well as those of various circuits[1] have recognized a "case or controversy" under similar circumstances and have conferred standing upon those who have similarly sought to enjoin or challenge already enacted but not yet enforced legislation.

"A plaintiff who challenges a statute must demonstrate a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement." *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979) (*citing O'Shea v. Littleton*, 414 U.S. 488, 494 (1974)). "Where the plaintiff has alleged an intention to engage in a course of conduct... but [is] proscribed by a statute, and there exists a credible threat of prosecution...", the plaintiff should not be required to await the state's enforcement of the statute to pursue the claim. *Id.* (*citing Doe v. Bolton*, 410 U.S. 179, 188 (1973)); *see also Steffel v. Thompson*, 415 U.S. 452, 459 (1974). Moreover, "[w]here enforcement of a regulatory statute would cause plaintiff to sustain a direct injury, the action may be properly maintained, whether or not the public

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[1] *See, United Food and Commercial Workers Int'l Union v. I.P.B., Inc.*, 857 F.2d 422 (8th Cir. 1988); *Michigan State Chamber of Commerce v. Austin*, 788 F.2d 1178 (6th Cir. 1986); *KVUE, Inc. v. Moore*, 709 F.2d 922 (5th Cir. 1983), *aff'd* 465 U.S. 1092 (1984); *Wilson v. Stocker*, 819 F.2d 943 (10th Cir. 1987); *Signorelli v. Evans*, 637 F.2d 853 (2d Cir. 1980); *Seattle School District No. 1 v. Washington*, 633 F.2d 1338 (9th Cir. 1980), *aff'd*, 458 U.S. 457 (1982).

officer has 'threatened' suit; **the presence of the statute is threat enough...**" 6A *Moore's Federal Practice*, ¶ 57.18 [2] at 57-189 (2d ed. 1987) (emphasis added); see also Footnote 1, *supra*. In *Babbitt*, this Court found persuasive the fact that the state had not disavowed any intention of enforcing a criminal penalty in ruling that there was ample reason in such a case for plaintiff to credibly fear prosecution, thus creating a justiciable controversy. 442 U.S. at 302. In the instant case, the Petitioners are legitimately threatened by already enacted legislation and are in no better position at a later date than they are now to challenge the validity of the MinnesotaCare statute under the Supremacy Clause of the United States Constitution. Accordingly, this Court's past pronouncements are indeed opposite and in conflict to the decision that the Eighth Circuit issued below.

B. The Eighth Circuit misapplied the law with respect to this Court's prior precedents involving similar justiciability and standing issues.

Explicit in Minn. Stat § 62J.35, subd. 2, is the penalty for non-compliance with respect to providing data under the entire MinnesotaCare statute, including Minn. Stat. § 62J.38. Those penalties include revocation of a license or other disciplinary or regulatory action or a fine imposed by the Commissioner of Health. Ultimately, the threat of enforcement is an ongoing injury which is more than imaginary or speculative because the Legislature has already enacted the MinnesotaCare statute and the state cannot rule out the possibility of future enforcement. *See Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 and 302 (1979) and *Steffel v. Thompson*, 415 U.S. 452, 459 (1974). In its decision, the Eighth Circuit relied heavily upon *Whitmore v. Arkansas*, 495 U.S. 149 (1983) and seemingly ignored the precedent established in *Babbitt* and *Steffel*. The Eighth

Circuit's reliance on *Whitmore* is misplaced. *Whitmore* dealt with a case where the petitioner's "injury in fact" was based on a future possibility of injury that was in essence virtually impossible. To no one's surprise, this Court in *Whitmore* ruled that the Plaintiff's alleged injury was "too speculative." 495 U.S. at 157 (1983). This case cannot be considered even remotely similar to the high degree of speculation that was presented in *Whitmore*, which was a case dealing with a petitioner who was convicted of murder, sentenced to death and had exhausted all of his appeals but yet wanted to challenge Arkansas' "system of comparative review" in death penalty cases. 495 U.S. at 156. The precise issue presented here involves an overlap of standing and ripeness considerations and the determination of which can be resolved by construing and interpreting the MinnesotaCare statute.

Ultimately, the Eighth Circuit concluded that Petitioners did not have standing to assert that the data collection and reporting provisions of MinnesotaCare were preempted by ERISA. In arriving at this conclusion, the Eighth Circuit relied upon Minn. Stat. § 62J.35 (1994) and the emergency rules (Minn.R. pt. 4652.0110) promulgated by the Commissioner of Health. Under the Eighth Circuit's view, the emergency rules were determinative in resolving the standing issue in favor of a permissive interpretation of the data collection and reporting requirements of MinnesotaCare on employer based self-insured ERISA plans. As a result, the Eighth Circuit specifically upheld and adopted verbatim the district court's conclusion that "as the statute is currently enforced, therefore, the plaintiffs 'are not required to submit health care revenue and expenditure data, but are merely 'encouraged' to do so." Eighth Circuit's Decision at App. A-8, 1995 (*quoting Boyle v. Anderson*, 849 F.Supp. 1307, 1311 (D. Minn. 1994)). Accordingly, Petitioners' claim was ruled as non-justiciable for a lack of standing. This conclusion is contrary to the established law of this Court and should be reversed.

C. The Eighth Circuit's construction of the MinnesotaCare statute was misplaced and should have conferred standing on petitioners based on the statute's provisions and the legislative intent.

In order to determine whether Petitioners suffered an injury that warrants standing under Article III of the United State's Constitution, the interpretation of the MinnesotaCare statute is the ultimate touchstone. The Eighth Circuit's decision was premised on an interpretation that the MinnesotaCare statute was permissive in that it gave the Commissioner of Health the discretion to require data collection from ERISA based plans. The Eighth Circuit was persuaded by the fact that the Commissioner of Health promulgated emergency rules mandating data collection from group purchasers while excluding self-insured employer based ERISA plans. Given the fact this litigation was commenced on June 4, 1993, it is no surprise that the Commissioner of Health would enact emergency rules in 1994 that did not require ERISA based plans to provide the data mandated from other group purchasers. Such reliance is suspect considering that the state has the ability to change the scope of those regulations at any point in time and the statute makes it clear that if the data pursuant to that section is requested, the obligation to provide it becomes mandatory for ERISA based plans.

Moreover, the MinnesotaCare statute viewed through the prism of legislative intent reasonably indicates that data will eventually be collected from ERISA based plans in order to compile necessary and accurate information to effectively administer MinnesotaCare. Notably, the content of Minn. Stat. § 62J.38 is different from that contained in § 62J.35. Minn. Stat. § 62J.35 provides for data collection for the purpose of assisting the commissioner in forecasting rates of

growth in health care spending and setting limits in health care spending under Minn. Stat. § 62J.04, subds. 1 and 1a. Section 62J.35 provides for the collection of data on patient revenues and health care spending. By contrast, Minn. Stat. § 62J.38 provides for collection of a broader range of data from group purchasers, including data for calendar years 1990, 1991, and 1992, as well as 1993 and successive years. The required data includes data on revenue, distinguishing between premium revenue from participants and from all other sources, as well as information on the amount of reserves and change in reserves. Expense data under the statute must include raw data from claims, and must be provided separately for physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures and administrative costs. Minn. Stat. § 62J.38(b). Moreover, group purchasers must provide data on a mandatory basis to the commissioner on quality of care, utilization of care, and outcome data. Minn. Stat. § 62J.42. The state has also mandated the establishment of a data institute. Minn. Stat. § 62J.45. The commissioner is mandated to establish the data institute to collect and process the data required to be submitted under Minnesota Statutes Chapter 62J. Minn. Stat. § 62J.45, subd. 5. The state legislature has specifically directed that the data enumerated in Minn. Stat. § 62J.38 and Minn. Stat. § 62J.42 be collected, either directly by the commissioner or through a vendor selected in consultation with the data institute. Minn. Stat. § 62J.45, subd. 10.

A careful review of the provisions of Minn. Stat. § 62J.35, Minn. Stat. § 62J.38 and Minn. Stat. § 62J.45 reveal that the obligations set forth in the various sections of the data collection statutes are not the same, nor is the purpose for requiring data through each section the same. Consequently,

the existence of Minn. Stat. § 62J.38, even in the absence of any current regulations or a plan of action from the data institute, represents the type of threatened action which gives rise to standing and ripeness to assert the current challenge.

Moreover, even if Minn. Stat. § 62J.35 is the only statutory provision which has effect, assuming that the Commissioner of Health is able to independently negate the provisions of Minn. Stat. § 62J.38, that provision contains compulsory compliance language available to the commissioner at any point she may elect to enforce collection of the data under that statutory section from self-funded health plans. This mandatory compliance language is sufficient under the standard announced by this Court in *Babbitt* to create a statutory presence which is threat enough to confer standing. Accordingly, Petitioners can appropriately challenge the statutory sections as preempted under ERISA.

CONCLUSION

For all the reasons stated, Petitioners pray that this Court grant a Writ of Certiorari to review the decision of the United States Court of Appeals for the Eighth Circuit.

Respectfully submitted,

HESSIAN, McKASY & SODERBERG
Professional Association
William A. Cumming
Attorney Reg. Number 175067
Lee A. Henderson
Attorney Reg. Number 126305
4700 IDS Center
Minneapolis, Minnesota 55402
Telephone: (612) 330-3000

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Affidavit of Dorine A. Pauly with Exhibit A A-113

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 94-2237 MN

PATRICK BOYLE, JAMES DAUGHERTY, P. DAN GILBERT, LARRY JORDAN, CHARLES MALONEY, THOMAS MARTIN, ROBERT SCHWARTZBAUER, and GARY THADEN, as the Board of Trustees of the Twin City Pipe Trades Welfare Trust, et al.	*
Appellants,	* Appeal from the United States District Court for the District of Minnesota
v.	*
MORRIS ANDERSON, in his capacity as the Commissioner of the Minnesota Department of Revenue, et al. Minnesota,	*
Appellees.	*

Submitted: December 12, 1994

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Before RICHARD S. ARNOLD, Chief Judge, FAGG, Circuit Judge, and WILSON,[1]* District Judge.

WILSON, District Judge

Plaintiffs-appellants challenged certain provisions of the Minnesota health care reform legislation known as MinnesotaCare. This lawsuit was filed by the trustees of thirteen self-insured welfare benefit plans that provide health care benefits to their 75,000 members, who reside in Minnesota as well as in other states. The welfare benefit plans were created and operate under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 USC 1001, et seq. The plans are funded through contributions by the covered workers and their employers. Appellants contended that ERISA and the Labor Management Relations Act (LMRA) preempted the "passthrough" to their plans of any part of a 2 percent gross receipts tax imposed by the MinnesotaCare statute on hospitals and other health care providers. Appellants also challenged the data reporting provisions and spending cap provisions of the statute. Defendants-appellees are the commissioners of the Minnesota Departments of Revenue, Health, and Human Services, and the director of the program providing health care coverage to low-income uninsured people in the state. The District Court, the Honorable Paul A. Magnuson presiding, granted summary judgment for defendants, ruling that plaintiffs did not have standing to challenge the data reporting provisions and spending cap provisions of the statute. Judge Magnuson further ruled that the provider tax portions of the statute are not preempted by ERISA or the LMRA. We affirm.

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*[1] The Honorable William R. Wilson, Jr., United States District Judge for the Eastern District of Arkansas, sitting by designation.

SUMMARY JUDGMENT

We review a grant of summary judgment de novo. Summary judgment is appropriate where there are no genuine issues of material fact and a party is entitled to judgment as a matter of law. -Fed.R.Civ.P. 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1985). Where the unresolved issues are primarily legal rather than factual, summary judgment is particularly appropriate. Crain v. Board of Police Commissioners, 920 F.2d 1402, 1405-1406 (8th Cir. 1990). The Supreme Court has stated that "summary judgment procedure is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole." Celotex, 477 U.S. at 327, 106 S.Ct. at 2555.

BACKGROUND

In April, 1992, the Minnesota Health Right Act, now known as MinnesotaCare, became law. The legislators' purpose in passing the law was to reduce health care costs and make health care available for all people in Minnesota. MinnesotaCare created several programs, including one to provide health coverage for low-income uninsured people. The Act also created a Health Care Commission to set limits on health care inflation and take other actions intended to reduce health care costs. To implement the legislation, the Department of Health has promulgated rules regarding collection of data from providers and purchasers of health care to help establish limits on the growth of health care spending. The MinnesotaCare programs are funded by several sources, including a 2 percent tax on gross patient revenues of hospitals, a 2 percent tax on gross revenues of non-hospital health care providers, a cigarette tax increase, and other taxes. In 1994 the Legislature directed the Health Care Commission

to re-evaluate the financing structure of the health care reform program, providing that "To the extent possible, universal coverage should be achieved without a net increase in total health spending, taxes, or government spending by recapturing savings and reallocating resources within the system... To the extent that universal coverage will require additional funding, revenues may be raised by reducing other general fund spending or through a variety of funding options, including broad-based taxes such as income or payroll." Chapter 625, Art. 6, Section 6, 1994 Minn. Laws 1572.

Hospitals and health care providers are able to pass the cost of the MinnesotaCare 2 percent provider tax to others. The law permits a provider to transfer the expense of the provider tax to third party purchasers such as insurance companies, health maintenance organizations (HMOs), or self-insured employee health plans. The passthrough provision states:

> A hospital, surgical center, pharmacy, or health care provider that is subject to a tax under Section 295.52, may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. The expense must not exceed two percent of the gross revenues received under the third-party contract, including copayments and deductibles paid by the individual patient or consumer.... All third-party purchasers of health care services ....must pay the transferred expense in addition to any payments due under existing or future contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. Nothing in this subdivision limits the ability of a hospital, surgical center, pharmacy or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing

fees or charges. Minn. Stat. Section 295.582 (Supp. 1993).

This provision makes it clear that it is not intended to limit the ability of a provider to recover all or part of its tax obligations by other methods, so that providers retain whatever legal right they may otherwise have to recover the cost of the 2 percent tax from purchasers of their services by increasing their charges. If providers use the method of increasing their charges for health care services, third-party purchasers do not receive a separate itemized charge for the provider tax, but they have to pay greater amounts for the services than they would have before the passage of MinnesotaCare.

ERISA

In cases involving preemption analysis, the Supreme Court has ruled that "the purpose of Congress is the ultimate touchstone." Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747, 105 S.Ct. 2380, 2393, 85 L.Ed.2d 728 (1985), citing Malone v. White Motor Corp., 435 U.S. 497, 504, 98 S.Ct. 1185, 1190, 55 L.Ed.2d 443 (1978). In passing ERISA, Congress intended to free employee benefit plans from the threat of conflicting or inconsistent regulations by different states. Fort Halifax Packing Company v. Coyne, 482 U.S. 1, 9, 107 S.Ct. 2211, 2216, 96 L.Ed.2d 1 (1987). As the Supreme Court concluded in a recent case involving the ERISA preemption provision: "The basic thrust of the preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." New York State Conference of Blue Cross & Blue Shield Plans, et al., v. Travelers Insurance Company, et al., 115 S.Ct. 1671, 63 USLW 4372 (1995). The statute provides that it shall "supersede any and all State laws insofar as they may now or

hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. 1144(a). The Supreme Court has held that the words "relate to" should be "construed expansively: 'a law relates to an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan." Shaw v. Delta Airlines, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983).

Despite this expansive interpretation of the statute, the Supreme Court has stressed that there are limitations to ERISA's preemption clause. Ingersoll Rand Co. v. McClendon, 498 U.S. 133, 139, 111 S.Ct. 478, 483, 112 L.Ed.2d 474 (1990). Notwithstanding the variety of opportunities for federal preemince, the Supreme Court has "never assumed lightly that Congress has derogated state regulation, but instead we have addressed claims of preemption with the starting presumption that Congress does not intend to supplant state law." Travelers, supra, 115 S.Ct. at 1676 (citing Maryland v. Louisiana, 451 U.S. 725, 746, 101 S.Ct. 2114, 2128, 68 L.Ed.2d 714 (1981). In addressing allegations that federal law bars state action in fields of traditional state regulation, the Travelers Court emphasized that "we have worked on the assumption 'that the historic police powers of the states were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." Id., citing Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947). The Court cautioned that "If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for 'really, universally, relations stop nowhere.' H. James, Roderick Hudson xli (New York ed., World's Classics 1980)." Travelers, at 1677. The Court stressed that such an expansive interpretation of the preemption clause 'would be to read Congress' words of limitation as mere sham, and to read the

presumption against preemption out of the law whenever Congress speaks to the matter with generality." Id.

As the District Court noted, the Supreme Court in Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988) held that the clause did not preempt a state garnishment statute, and in Fort Halifax, supra, decided that a state severance pay statute was not preempted by ERISA. Similarly, the Court concluded that Congress did not intend ERISA "to preempt areas of traditional state regulation." Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740, 105 S.Ct. 2380, 2389, 85 L.Ed.2d 728 (1985). ERISA's preemption provisions must be guided by "respect for the separate spheres of governmental authority preserved in our federal system." Alessi v. Raybestos-Manhattan, 451 U.S. 504, 522, 101 S.Ct. 1895, 1905, 68 L.Ed.2d 402 (1981). Furthermore, the Supreme Court has ruled that ERISA does not preempt "a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." Metropolitan Life, supra. In Shaw, supra, the Court concluded that "some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Shaw, at 100n.21, 2901n.21.

ISSUE OF STANDING REGARDING DATA COLLECTION AND REPORTING PROVISIONS OF MINNESOTACARE

Appellants contend that the data collection and reporting provisions of MinnesotaCare are preempted by ERISA because they allegedly represent direct regulation of the appellants' plans. The reporting requirements are discussed in two sections of the statute. Section 62J.35 states that the Commissioner of the Minnesota Department of Health "may

collect from health care providers data on patient revenues and health care spending during a time specified by the commissioner." Section 62J.38 states that the commissioner "shall require group purchasers to submit detailed data on total health care spending...." In order to implement these provisions, the Commissioner promulgated emergency rules concerning the data collection and reporting requirements. Minn.R.pt. 4652.0110 provides: "The following group purchasers, as defined under part 4652.0100 [Emergency], subpart 14, are subject to the reporting requirements established by part 4652.0120 [Emergency]: all insurance companies ... that reported $10,000 or more in total health premiums to the Department of Commerce in 1991; and all health service plan corporations.... Employee health plans offered by self-insured employers will be encouraged to comply with these reporting requirements." The rules promulgated by the Commissioner of Health resolved the apparent conflict in the two statutory provisions in favor of the permissive authority stated in Section 62J.35. The Commissioner has not included ERISA plans in the mandatory data collection and reporting rules. Therefore, employer-based self-insured ERISA health plans "will be encouraged to comply with these reporting requirements", but they are not required to do so. The District Court was correct in the conclusion that "as the statute is currently enforced, therefore, the plaintiffs 'are not required to submit health care care revenue and expenditure data, but are merely 'encouraged' to do so." Boyle v. Anderson, 849 F.Supp. 1307, 1311 (D.Minn. 1994).

Article III of the United States Constitution confines the federal courts to adjudicating actual "cases and controversies." Allen v. Wright, 468 U.S. 737, 750, 104 S.Ct. 3315, 3324, 82 L.Ed.2d 556 (1984) Standing is a threshold issue in every case before a federal court, determining the power of the court to entertain the suit. Warth v. Seldin, 422 U.S. 490, 498, 95

S.Ct. 2197, 2204, 45 L.Ed.2d 343 (1975). A federal court's jurisdiction can be invoked only when plaintiffs have suffered "some threatened or actual injury resulting from the putatively illegal action." Linda R.S. v. Richard D., 410 U.S. 614, 617, 93 S.Ct. 1146, 1148, 35 L.Ed.2d 536 (1973). The Supreme Court defined the constitutional requirements of standing in Allen v. Wright, 468 U.S. 737, 751, 104 S.Ct. 3315, 3324, 82 L.Ed.2d 556 (1984): "A plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." Plaintiffs have the burden of proof in establishing standing. Lujan v. Defenders of Wildlife, 112 S.Ct. 2130, 2136 (1992). The District Court in the instant case correctly concluded that since the reporting requirements do not apply to plaintiffs, they have failed to meet their burden of showing that they were in any way injured by the reporting requirements of MinnesotaCare. Plaintiffs have not met the essential injury element, and hence they did not have standing to challenge the reporting requirements.

Plaintiffs contend that the State of Minnesota might at some point in the future change its position and require compliance with the data requirements. The Supreme Court has repeatedly emphasized that the injury must be concrete in both a qualitative and temporal sense: "The complainant must allege an injury to himself that is 'distinct and palpable,' Warth, supra, 422 U.S., at 501, 95 S.Ct. at 2206, as opposed to merely 'abstract,' O'Shea v. Littleton, 414 U.S. 488, 494, 94 S.Ct. 669, 675, 38 L.Ed.2d 674 (1974), and the alleged harm must be actual or imminent, not 'conjectural' or 'hypothetical.'" Whitmore v. Arkansas, 495 U.S. 149, 156, 110 S.Ct. 1717, 1723, 109 L.Ed.2d 135 (1990), citing Los Angeles v. Lyons, 461 U.S. 95, 101-102, 103 S.Ct. 1660, 1664-1665, 75 L.Ed.2d 675 (1983). In summarizing the holdings of numerous cases, the Supreme Court stated that these precedents demonstrated "what we have said many times

before and reiterate today: Allegations of possible future injury do not satisfy the requirements of Article III. A threatened injury must be 'certainly impending' to constitute injury in fact." Whitmore, 495 U.S., at 160, 110 S.Ct., at 1725. Plaintiffs' allegation that the Commissioner could reverse her position and require compliance with the data requirements is a conjectural allegation of "possible future injury" and does not meet the requirements for an injury in fact. The District Court here was correct in concluding that plaintiffs were requesting an advisory opinion to deal with the possibility that at some point in the future the State might revise the reporting requirements to make them applicable to the Plaintiffs. Boyle, supra, at 1312. The Supreme Court has held that "The oldest and most consistent thread in the federal law of justiciability is that the federal courts will not grant advisory opinions." Flast v. Cohen, 392 U.S. 83, 96-97, 88 S.Ct. 1942, 1950-51, 20 L.Ed.2d 947 (1968)(quoting C. WRIGHT, THE FEDERAL COURTS, 34 (1963).

THE STANDING ISSUE CONCERNING THE SPENDING CAP PROVISIONS

Plaintiffs alleged that the spending cap provisions of MinnesotaCare would cause them to "monitor claims expenses during a calendar year to attempt to forecast whether claims expenses will exceed the additional amount authorized by the Commissioner of Health." (Appellant's brief, July 7, 1994, at 20). The spending cap provisions apply to 'health carriers." Minn. Stat. 62P.04 (Supp. 1993). Yet, plaintiffs are not within the statutory definition of health carriers, and therefore they are not subject to the regulation limiting increases in costs. Minn.Stat. 62A.011 (Supp.1993). Since Plaintiffs are not required to comply with the spending caps, they have not demonstrated an injury in fact and thus have again failed to establish standing. The District Court was correct in granting

summary judgment in favor of defendants on the issue of the spending cap provisions.

THE PROVIDER TAX ISSUES

The District Court found that the provider tax provisions of MinnesotaCare "related to" the employee benefit plans, and thus were within the scope of ERISA's preemption clause. The Eighth Circuit has established a series of factors to be considered in deciding whether a state statute of general application is preempted by ERISA. Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., 947 F.2d 1341, 1344-45 (8th Cir. 1991)[Arkansas BCBS]. Before applying these factors, however, the Court must determine whether the statute is "of general application." A law of general applicability is one that does not treat ERISA plans differently from non-ERISA plans. New England Health Care Employees Union District 1199 v. Mount Sinai Hospital, 846 F.Supp. 190 (D.Conn., 1994); Mackey v. Lanier Collection Agency & Service, 486 U.S., 825, 830, 108 S.Ct. 2182, 2185, 100 L.Ed.2d 836 (1988). As this Court explained in Arkansas BCBS, statutes of general application "can be distinguished from statutes that actually or implicitly refer to ERISA plans." Arkansas BCBS, at 1345n.3. The Arkansas BCBS Court cited the section of Mackey in which the Supreme Court held that Ga. Code Ann. 18-4-22.1, "which singles out ERISA employee welfare benefit plans for different treatment under state garnishment procedures, is preempted under Section 514(a)." Mackey, 486 U.S., at 830, 108 S.Ct. 2182, 2186. The Mackey Court noted that the Georgia statute at issue "expressly refers to--indeed, solely applies to--ERISA employee benefit plans." Id., at 829, at 2185. In the case at bar, the provider tax and passthrough provisions of MinnesotaCare do not explicitly refer to ERISA plans, nor do they single out ERISA purchasers of health care for different

treatment. The tax applies to all hospital and health care providers, and the passthrough applies to all third-party purchasers. The provider tax does not apply to ERISA plans differently than non-ERISA plans, and it is a statute of general application.

Appellants rely upon Boise-Cascade Corp. v. Peterson, 939 F.2d 632 (8th Cir.1991), cert. denied, 112 S.Ct. 3014 (1992), but it is not on point. In Boise-Cascade, the Court held that a Minnesota legal rule mandating the ratio of journeymen to apprentices in pipefitter training programs was preempted by ERISA. Boise-Cascade, at 637. The Court concluded that this "minimum jobsite rule was specifically designed to affect employee benefit plans. The very purpose of the minimum jobsite rule was to require plaintiffs and other employers to train their apprentices in accordance with the minimum jobsite rule." Id. The rule "directly" affected an ERISA plan, since it regulated certain terms and conditions of the apprenticeship programs by "establishing the manner in which employers can train and employ both journeymen and apprentice pipefitters." Id. at 638. As stated earlier, in the case at bar, the provider tax and passthrough provisions are not directly involved with the terms of ERISA plans and do not single out the ERISA plans for special treatment; and these MinnesotaCare provisions affect all hospitals and health care providers and non-government third-party purchasers alike.

NEGATION OF AN ERISA PLAN PROVISION AND RELATION TO OTHER ERISA STATUTORY PROVISIONS

Courts must look upon the "totality of the state statute's impact on the plan," and no one factor is determinative of the ERISA preemption issue. Id. at 1345. The District Court

appropriately considered the factors stated in Arkansas BCBS, supra.

The Arkansas BCBS factors first focus upon a determination whether the provider tax negates a plan provision or relates to other ERISA statutory provisions. Id. Appellants assert that the provider tax contravenes provisions of the plan as well as provisions of ERISA, because the tax raises costs to the plans. Appellants cite 29 U.S.C. 1103(c)(1), which provides that "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." The effect of the provider tax, according to appellants, is to increase costs to the plans because the tax revenue will be used to fund the state's program of health care for low-income uninsured people who are not benefiaries of the plans, thus allegedly violating the "exclusive benefits" provision of ERISA.

Appellees contend that appellants' argument stretches ERISA's exclusive benefit provision beyond the boundaries intended by Congress. The District Court noted that Section 1103(c)(1) and 29 U.S.C. 1104(a) deal with fiduciary duties for plan administrators and employers. The relevant passage states: "A fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and-- (a) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan;...." 29 U.S.C. 1104(1)(A). Congress included these provisions in order to make the law of trusts applicable to the plans and to eliminate "such abuses as self-dealing, imprudent investing, and misappropriation of plan funds." Fort Halifax Packing Co. v. Coyne, supra, 482 U.S., at 15, 107 S.Ct., at 2219. The legislative history made it clear that the legislation imposed strict fiduciary obligations on those having discretion or responsibility for the management

or disposition of pension or welfare plan assets. 120 Cong.Rec. 29,932 (1974)(Statement of Senator Williams on the Conference Report on ERISA). In summarizing the ERISA conference report, Senator Williams stated in the Congressional debate that "the objectives of these provisions are to make applicable the law of trusts; to prohibit exculpatory clauses that have often been used in this field; to establish uniform fiduciary standards to prevent transactions which dissipate or endanger plan assets; and to provide effective remedies for breach of trust." Id. The District Court correctly concluded that Congress was concerned with the issues cited above, and it was not concerned with whether persons not covered by ERISA plans were somehow benefitted by the operation of the plans. Boyle, at 1313.

The Third Circuit addressed a similar issue regarding ERISA's exclusive benefits provision in United Wire, Metal and Machine Health & Welfare Fund v. Morristown Memorial Hospital, 995 F.2d 1179 (3d Cir.1993), cert. denied, 114 S.Ct. 382, 383 (1993). The United Wire Court stated that there are many forms of state regulation under the police power that lead to increases in the costs of doing business and increases in prices "where the beneficiaries of the regulation are not those who are paying the increased prices." United Wire, at 1196. The Court cited the example that states have begun regulating the disposal of medical wastes in order to protect people who would otherwise suffer from "socially irresponsible disposal." Id. "Such regulations," the Court concluded, "can significantly increase a hospital's cost of doing business and, accordingly, its billings to plan participants. We are confident, however, that ERISA was not intended to foreclose a state regulation of this kind... In short, we are unwilling to attribute to Congress and Section 514 an intent to frustrate efforts of a state, under its police power, to regulate health care costs." Id.

The exclusive benefits provisions were intended to prohibit the kinds of wrongful diversions of trust assets that

members of Congress discussed in the Congressional debate concerning ERISA fiduciary standards. The indirect benefit enjoyed by others when providers pass through to the plans the cost of the provider tax neither negate a plan provision nor contradict any provision of ERISA requiring "exclusive benefit," and thus these factors weigh against a finding of preemption.

EFFECT ON PRIMARY ERISA ENTITIES AND IMPACT ON PLAN STRUCTURE

If the provider tax alters relationships among the primary ERISA entities--the employer, the plan, the plan fiduciaries, and the beneficiaries--and thereby changes the structure of the plan, then this factor weighs in favor of preemption. Arkansas BCBS, at 1346. The Court in Arkansas BCBS found that the state law at issue in that case altered the plan structure by transferring the power to determine who could receive benefits under a plan from the plan adminstrator to the beneficiaries. Appellee is correct in distinguishing the statute in Arkansas BCBS from the statute in the instant case. In Arkansas BCBS, the challenged law made all bills, notes, and other written arrangements for the payment of money assignable, meaning that the insurer for an ERISA health plan had to accept assignments of insurance benefits made by plan beneficiaries despite the fact that the terms of the plan gave the plan the right to determine who should receive payment. The Court concluded that the Arkansas assignment statute impermissibly altered relationships among primary ERISA entities and changed the plan structure by Liking the power to decid. who would receive benefit payments under the plan from the plan administrator and giving it to the beneficiaries.

The MinnesotaCare provider tax clearly differs from the Arkansas statute at issue in Arkansas BCBS. The passthrough of the provider tax would only cause the plans to pay a slightly

increased fee for health care services already covered under the plans; it would not add benefits, nor would it shift any power among plan entities. As the District Court observed, none of the plans answering defendants' interrogatories identified any changes in plan documents or other effects on plan structure as a result of the tax.

Plaintiffs rely upon their exclusive benefits theory to contend that the provider tax exerts an impact on plan structure. Since plan assets are used to provide benefits to some people who are not plan beneficiaries by the provider tax, plaintiffs argue that these people thereby become additional plan beneficiaries. This alleged designation of additional beneficiaries "relates to" the plan and its structure, plaintiffs assert, and thus the passthrough is preempted. This argument is basically a rehashing of the "exclusive benefit" theory plaintiffs presented about the issues already discussed concerning "negation of a plan provision and relation to other ERISA statutory provisions." The ERISA exclusive benefits provision does not prohibit every indirect benefit to people other than plan beneficiaries. Plaintiffs again are overreaching in their interpretation of the exclusive benefits provision in claiming that anyone who gains indirect benefits is thereby transformed into a beneficiary; as Judge Magnuson correctly stated, such a view would mean that every state law that led to increases in plan costs--such as sales tax, minimum wage or environmental regulation statutes--would be preempted.[2]

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[2] Plaintiffs cite Bricklayers Local No. 1 v. Louisiana Health Insurance Association, 771 F. Supp. 771 (E.D.La.1991) in making their exclusive benefit argument. The Louisiana District Court's opinion in Bricklayers has no binding authority upon this Court, which declines to follow the reasoning of that decision. Bricklayers espoused an expansive view of the exclusive benefits theory, in the context of a state statute that required hospitals to impose additional charges, whereas in this case the passthrough is voluntary. Moreover, the Bricklayers Court failed to consider the legislative intent and legislative history of the exclusive benefits provision, nor did it analyze the implications of its decision for

Boyle, at 1314. The provider tax does not result in any alteration in the authority of the primary ERISA entities, nor does it have an impact on the terms of the plan itself, thus, this factor weighs against preemption.

IMPACT ON ADMINISTRATION OF THE PLANS

A state law can have both an intrastate and interstate impact on the administration of ERISA plans. Arkansas BCBS, at 1346. In Arkansas BCBS, the Court ruled that the statute had an impact on intrastate plan administration because it gave plan beneficiaries control of assignments of benefits. Id. at 1347. This imposed an extra administrative burden on plan officials in determining on an individual basis to whom benefits should be paid. In MacLean v. Ford Motor Company, 831 F.2d 723 (7th Cir. 1987), the Court held that ERISA preempted a state testamentary law. In MacLean, however, the Court had also relied on another factor--negation of a plan term--in finding preemption, and the testamentary law at issue required the plan administrator to distribute the deceased employee's pension assets according to the employee's will rather than using the method provided for in the plan. MacLean, at 728. The Arkansas BCBS Court conceded that courts have disagreed whether a state law that requires an administrator to distribute plan benefits in a certain way has more than a tenuous impact on administration. Arkansas BCBS, at 1347. The Court noted that the Supreme Court in Mackey, 486 U.S., at 831-40 (state garnishment law) and the Second Circuit in Aetna Life Insurance Company v. Borges, 869 F.2d 142, 147-148 (2d Cir. 1989) (state escheat law)

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the numerous costs that are already included in hospital charges. As previously stated, the Court finds the Third Circuit's interpretation of the exclusive benefits provision stated in United Wire, discussed above, to be clearly superior to the expansive approach in Bricklayers.

found that state statutes affecting benefit distribution did not "relate to" ERISA plans. The Court distinguished between the statutes in Mackey and Aetna by emphasizing that "Unlike the Arkansas assignment statute, state garnishment and escheat statutes do not shift control over benefit distribution." Id.

Judge Magnuson correctly concluded that the passthrough does not impose an administrative burden. The passthrough does not require a claims administrator to analyze each claim based upon potentially divergent, individual assignments of benefits. Plaintiffs did not identify any additional administrative actions taken or costs incurred as a result of the passthrough. As the District Court pointed out, plaintiffs' answers to interrogatories acknowledged that the sole administrative inefficiency "was that in the rare instances of hospitals that submit a separate billing for the provider tax, an extra administrative cost is incurred in processing that additional payment." Boyle, at 1315. The usual methods of passing through the provider tax, however, are "including it in increased charges or by adding the passthrough as a separate item on the hospital bill." Id. Appellants have not identified any administrative impact caused by these methods, which involve the vast majority of the passthrough of the tax. Thus, appellees are correct that the tax does not have a genuine intrastate administrative impact.

In arguing that the tax affects interstate administration, appellants contend that plan beneficiaries in Minnesota will be subject to the tax, while plan participants living outside of Minnesota will not be subject to the tax. When a state law has an interstate administrative impact on ERISA plans because multi-state plans would be subject to potentially conflicting laws of 50 states, this factor favors preemption. Arkansas BCBS, at 1348. The Supreme Court has stressed that a main purpose of ERISA was the protection of plan participants from the threat of inconsistent state regulation. Fort Halifax, 482 U.S., at 9-10. The Arkansas BCBS Court found that the

Arkansas assignment statute could conflict with assignment statutes in other states, thus causing plan administrators to engage in a meticulous evaluation of each claim and creating "numerous administrative difficulties for multi-state ERISA plans." Arkansas BCBS, at 1348. In contrast, plan administrators involved here do not have to be concerned about conflicting state laws. The case law does not indicate that a minor difference in cost of services among the states would lead to a finding of preemption. The Supreme Court emphasized in FMC Corp. v. Holliday, 498 U.S. 52, 111 S.Ct. 403, 407 (1990) that requiring plan providers "to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits." Where a patchwork of regulations would inject "considerable inefficiencies in benefit program operation," the Supreme Court has applied the preemption clause to make certain that plans are governed by only a single set of regulations. Fort Halifax, 482 U.S., at 11, 107 S.Ct., at 2217. No such "considerable inefficiencies" and complications are present in the instant case.

The provision produces the impact that the price for health care services may differ from state to state, but this will not cause them to redesign their plans or cause inefficiencies. The District Court stressed that plaintiffs' answers to interrogatories revealed that their plans are presently organized to accommodate different costs for similar services; the plans indicated that the hospital charges they pay for the same services vary, and they acknowledged that the differential among the charges exceeds two percent. Boyle, at 1315. Thus, the possibility that an extra two percent will be payable on some bills but not on others cannot involve

additional administrative expense and does not cause difficulties for the plans to operate on a multi-state basis.[3]

Intrastate as well as interstate administrative impact of state statutes may be "only tenuous," leading courts to the conclusion that they are not the "type[s] of laws Congress intended to preempt." Aetna, 869 F.2d, at 147-148. The provider tax has too tenuous, remote and peripheral an intrastate and interstate administrative impact, and the District Court was correct in its ruling that this factor weighs against a finding of preemption.

ECONOMIC IMPACT

The Arkansas BCBS Court ruled that tenuous and peripheral economic impact, by itself, is not sufficient to find preemption. Arkansas BCBS, at 1348. The Court acknowledged, however, that "Like all the factors considered, ...simply because the existence of some economic impact is not dispositive of the preemption issue does not make this factor irrelevant to the preemption inquiry. In fact, this factor is highly relevant to whether the ... statute relates to ERISA plans." Id. Appellants contend that economic impact by itself caused by an indirect tax on an ERISA plan is sufficient to find preemption; in making this argument they place substantial reliance upon The Travelers Insurance Company v. Cuomo,

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[3] The District Court also pointed out that independent sources of information have found substantial price differences within Minnesota and in comparison to other states. See Council of Hospital Corporations, Revised Hospital Charges By Diagnosis Related Group, (November, 1990)(stating that there were variations in charges among Minnesota hospitals as well as in comparison to other states Wisconsin Department of Health & Social Services, Health Care Data Report, Hospital Utilization and Charges in Wisconsin (1991)(citing charges of Wisconsin hospitals for similar services that differ within Wisconsin and in comparison with Minnesota).

14 F.3d 708 (2dCir. 1993)(later reversed, as discussed below) and E-Systems, Inc. v. Pogue, 929 F.2d 1100 (5th Cir.1991). At the time the briefs were filed in this case, Circuit Courts differed in their analyses of the factor regarding economic impact of a state statute upon a plan. In E-Systems, the Fifth Circuit stated that the economic impact of a state law could by itself warrant a finding of preemption. E-Systems, at 1103. In the Second Circuit's Travelers decision, the Court held that a state statute that imposes "a significant economic burden" on ERISA plans "relates to" ERISA and is preempted. Travelers, at 721.

The view taken by the Ninth and Third Circuits differed from the Second and Fifth Circuits. More importantly, the Eighth Circuit in Arkansas BCBS clearly did not accept the view that economic impact alone could suffice for a finding of preemption, since it stressed that "We do not believe that any one factor, by itself, is determinative of the ERISA preemption issue..." Arkansas BCBS, at 1345. In Lane v. Goren, 743 F.2d 1337, 1340 (9th Cir. 1984), the Ninth Circuit rejected the view that every state law that increases the costs of an ERISA plan is preempted, explaining: "That argument does not withstand scrutiny. So, too, for example, do State law and municipal ordinances regulating zoning, health, and safety increase the operational costs of ERISA trusts, but no one could seriously argue that they are preempted." Similarly, the Third Circuit in United Wire, supra, rejected an ERISA preemption challenge and upheld a New Jersey hospital rate-setting law intended to contain health care costs. The Third Circuit explained: "Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees." United

Wire, at 1194. The Court concluded that "if ERISA is held to invalidate every state action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress." Id., citing Rebaldo v. Cuomo, 995 F.2d 1179 2d Cir.1984).[4]

After the parties filed their briefs in the case at bar, the recent Supreme Court decision in Travelers, supra, devoted substantial attention to the "economic impact" factor, reversing the Second Circuit's ruling in Travelers and stating a position that supports the Third Circuit in United Wire. Travelers, 115 S.Ct., at 1676. Travelers dealt with a New York statute that regulated rates for all in-patient care, except for services provided to Medicare beneficiaries. Patients are charged not for the cost of their individual treatment, but for the average cost of treating the patient's medical problem, as classified under one of almost 800 Diagnostic Related Groups (DRGs). Id. at 1674. The DRG classifications are adjusted to take into consideration each hospital's particular operating costs, investments, debts, costs of charity care, and other relevant characteristics. Patients with Blue Cross/Blue Shield coverage, Medicaid patients, and HMO participants are billed at the hospital's DRG rate, but others are not. Patients served by commercial insurers that provide in-patient hospital coverage on an expense-incurred basis, by self-insured funds directly reimbursing hospitals, as well as by "certain workers' compensation, volunteer firefighters' benefit, ambulance workers benefit, and no-fault motor vehicle insurance funds, must be billed at the DRG rate plus a 13 percent surcharge to be retained by the hospital. N.Y.Pub.Health Law 2807-c(l)(b)." Id. In addition, for the year ending March 31, 1993,

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[4] Another portion of Rebaldo was overturned in Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990), but the above-quoted reasoning is still sound.

hospitals had to bill commercially insured patients for a further 11 percent surcharge to be turned over to the state. The New York law further imposed a surcharge on HMOs that varied according to the number of Medicaid recipients the HMO enrolled; this surcharge could run as high as 9 percent of the aggregate monthly charges paid by an HMO for its members' in-patient hospital care. This assessment is a direct payment by the HMO to the state's general fund. Several commercial insurers who were acting as fiduciaries of ERISA plans filed suit to invalidate the 13 percent, 11 percent and 9 percent surcharges. Id. at 1675.

The Supreme Court rejected the Second Circuit's conclusion that the three surcharges 'relate to' ERISA because they impose a "significant economic burden" and therefore exert an impermissible impact on ERISA plan structure and administration. Id. at 1676. Justice Souter's opinion for the unanimous Court stated that since the surcharges are presumably passed on at least in part to those who buy commercial insurance or HMO membership, they "have an indirect economic effect on choices made by insurance buyers, including ERISA plans." Id. at 1678-1679. Nevertheless, the Court ruled that an indirect economic influence does not bind plan administrators to any specific choice "and thus function as a regulation of an ERISA plan itself; commercial insurers and HMOs may still offer more attractive packages" than the Blue Cross and Blue Shield plans. Id. at 1679. Such an indirect influence does not preclude uniform administrative policies, nor does it complicate a uniform interstate benefit package; it simply bears on the costs of benefits "and the relative costs of competing insurance to provide them." This influence can affect "a plan's shopping decisions," Justice Souter wrote, "but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges." Id. The Court found nothing remarkable about surcharges on hospital bills, observing that rate variations among hospital providers are

accepted examples of cost variation, "since hospitals have traditionally 'attempted to compensate for their financial shortfalls by adjusting their price... schedules for patients with commercial health insurance.'" Id. (citing Thorpe, Does All-Payer Rate Setting Work? The Case of the New York Prospective Hospital Reimbursement Methodology, 12 J. Health Politics, Policy & Law 391, 402 (1987). Even before state regulation, charge differentials for commercial insurers varied dramatically across regions, within a range from 13 to 36 percent, reflecting the geographically different burdens of providing for the uninsured. Id.

The Travelers Court concluded that if the common character of rate differentials without any state action makes it unlikely that ERISA was intended to preempt indirect economic influences of state laws, "the existence of other common state action with indirect economic effects on a plan's costs leaves the intent to preempt even less likely." For example, when the state sets quality standards in one subject area of hospital services but not another, such action would have an impact on the relative cost of those services over others, and thus of providing different packages of health insurance benefits. Id. "Even basic regulation of employment conditions," Justice Souter added, "will invariably affect the cost and price of services." In the instant case, hospitals pass through to third party payers such costs as those involved in disposal of hazardous chemicals, compliance with state OSHA standards; hospitals also pass on in their charges state unemployment compensation taxes, payroll taxes, and property taxes. (Affidavits of Douglas Fenstermaker, Exhibit J to affidavit of Richard Slowes). In reaching the conclusion that cost uniformity was not an object of preemption, the Court explained:

> Indeed, to read the preemption provision as displacing all state laws affecting costs and charges on the

theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services, would effectively read the limiting language in Section 514(a) out of the statute... While Congress' extension of preemption to all 'state laws relating to benefit plans' was meant to sweep more broadly than 'state laws dealing with the subject matters covered by ERISA, reporting disclosure, fiduciary responsibility, and the like, Shaw, supra, 463 U.S., at 98n.19, 103 S. Ct., at 2900n.19, nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern. [citations omitted]. In sum, cost uniformity was almost certainly not an object of preemption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans." [citation omitted]. Id. at 1680.

Justice Souter observed that the Court's conclusion was confirmed by the decision in Mackey, supra, in which the Court held that ERISA preemption falls short of barring application of a general state garnishment law to participants' benefits in the hands of an ERISA welfare benefit plan. The Court made that decision despite the fact that garnishment would impose administrative costs and burdens upon benefit plans. If a law authorizing indirect administrative costs is not preempted, the Travelers Court reasoned, then a law operating as an indirect source of economic impact on administrative decisions also should not trigger preemption. Id.

The Supreme Court stipulated that it was not holding that ERISA preempts only direct regulation of ERISA plans, because "We acknowledge that a state law might produce such

acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under Section 514." (emphasis added) Id. at 1683. New York's surcharges did not fall into either category, for they affected only indirectly the "relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." Id.

In the instant case, Judge Magnuson pointed out that the economic impact in Travelers was much greater than the relatively small provider tax of MinnesotaCare. Boyle, at 1316. Clearly, if the Supreme Court found the surcharges of thirteen, eleven and nine percent to be insufficient regarding the "economic impact' factor in Travelers, then the smaller tax involved in Boyle is obviously insufficient to. constitute the "acute, albeit indirect, economic effects" that "might" trigger preemption under the Travelers analysis.

Appellants cited E-Systems v. Pogue, supra, in support of its argument that economic impact alone is sufficient for a finding of preemption. In E-Systems, the Fifth Circuit dealt with a state statute that imposed a 2.5 percent tax on organizations receiving an administrative or service fee from self-funded health plans. E-Systems, at 1101. The tax also applied to the value of benefits processed by the administrator; the administrative provider of services to ERISA plans was charged the tax and the cost was passed through to the plans. The E-Systems Court stated that the State of Texas "contends that [the statute's] mere economic impact on a plan is an insufficient reason to invalidate the tax. We do not agree." Id. at 1103. The Fifth Circuit ruled that "The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it

enacted the ERISA legislation." Id. The statute at issue in E-Systems had a smaller economic impact than the one involved in Travelers.[5] E-Systems was an even more expansive interpretation of the preemption clause than the analysis of economic impact found in the Second Circuit's Travelers decision, which qualified its holding by finding that only a "significant economic burden" could serve as the basis for preemption. Travelers, 14 F.3d, at 721.[6] Appellees contend

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[5] Both parties discussed the question of how significant the economic impact of the provider tax will be. Appellants argued in their brief that Minnesota's program is underfunded and will have to be increased. This argument is based only upon newspaper reports. Furthermore, the Legislature commissioned a study of the MinnesotaCare programs and asked for recommendations that specifically included "broad-based taxes such as income or payroll." Chapter 625, Art. 6, Section 6, 1994 Minn.Laws 1572. Appellants' contention on this question is based upon speculation. Appellees contend that the actual economic impact is less than 2 percent, because MinnesotaCare will eventually have some indirect economic benefit in addition to the indirect economic burden of the tax. As uninsured people become covered by MinnesotaCare, the amount of uncompensated care incurred by providers will lessen, in appellees' view. Plaintiffs' answers to interrogatories indicated that the plans now pay hospital charges that include a component by which the hospitals recover uncompensated care. Appellees also assert that to whatever degree the provider tax reduces those amounts, the plans will have the benefit of offsetting reductions in hospital charges, and similarly, to the extent that "the provider tax is used to fund other facets of the cost containment component of the MinnesotaCare program, such as imposing uniform payment forms and procedures that cut administrative costs, the plans will also be benefited." While appellees present a plausible argument that the impact is some as yet undetermined amount less than 2 percent, this is not necessary regarding the economic impact argument, for even if there are no significant economic benefits from it, the 2 percent tax does not have a sufficient economic impact for it to weigh in favor of preemption.

[6] Judge Magnuson stated that the statute in E-Systems differed from the one in Boyle. The Texas statute imposed a tax on plans that were "virtually identical to those covered by ERISA. . . Thus, the Texas law

that the E-Systems Court had determined that "any" economic impact would warrant preemption. There is little discussion of this question in the E-Systems opinion and it is thus unclear whether the Court intended to go as far as appellees allege; but the view that any economic impact would be sufficient is clearly erroneous. Travelers, 115 S.Ct., at 1683. The E-Systems statement that Congress generally intended to eliminate state statutes with indirect economic effects is not correct in view of the Supreme Court's conclusion in Travelers that indirect economic effects that are "acute" might suffice for preemption; as Justice Souter's opinion stressed, Congress certainly did not intend to eliminate the innumerable state laws having indirect effects "in areas traditionally subject to local regulation." Travelers, 115 S.Ct., at 1683.

The Supreme Court devoted substantial attention to the legislative history of ERISA and other evidence of Congress' intent in passing ERISA. The Court pointed out that the basic Diagnostic Related Groups system, even without a surcharge, "like any other interference with the hospital services market, would fall on a theory that all laws with indirect economic effects on ERISA plans are preempted under Section 514(a)." Id. at 1681. Such an "unsettling result" would be all the more remarkable because several states--including New York, New Jersey, California, Maryland, and several others--regulated hospital charges at the time Congress passed ERISA. Id. Nothing in ERISA's legislative history indicates that Congress intended to eliminate these state laws. Id. Moreover, the same Congress that passed ERISA a few months later passed the National Health Planning and Resources Development Act

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'related to' ERISA plans on its face. . . In contrast, the MinnesotaCare provider tax does not involve direct taxation on services offered by ERISA plans." Boyle, at 1316. Whether or not the Texas and Minnesota statutes are different, it is clear that the E-Systems analysis of the economic impact factor is incorrect.

of 1974 (NHPRDA), which sought to encourage and help fund state responses to rising health care costs and the widely diverging availability of health services. Id. at 1682. The Court rejected the expansive interpretation of the preemption clause, stating that such a view would render the entire NHPRDA meaningless by denying states the authority to do what Congress was expressly trying to encourage them to do by enacting the legislation. Considering the reality that the NHPRDA was enacted after ERISA and by the same Congress, Justice Souter wrote, "it just makes good sense to reject such an interpretation." Id. The history of Medicare regulation illustrates the same point, the Court stressed, "confirming that Congress never envisioned ERISA preemption as blocking state health care cost control, but rather meant to encourage and rely on state experimentation like New York's." The Travelers Court followed Justice Brandeis' admonition that Courts should be wary of obstructing the states in their varied efforts to grapple with the great public issues of the day: "Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." 285 U.S. 262, 52 S.Ct. 371, 76 L.Ed. 747, New State Ice Co. v. Leibmann, (1932)(Brandeis, J., dissenting). Justice Souter cited the U.S. House of Representatives' report on the Social Security Amendments of 1983, in which the the Ways and Means Committee emphasized that "State systems provide a laboratory for innovative methods of controlling health care costs, and should, therefore, not be limited to one methodology." Travelers, at 1682n.6, citing H.R.Rep. No. 98-25, pt. 1, pp. 146-147 (1983) U.S. Code Cong. & Admin. News 1983 pp. 143, 365, 366. In the context of the MinnesotaCare legislation, Travelers and the other precedents

cited in this litigation compel this Court not to preempt a state's effort to serve as a "laboratory of democracy" in the realm of health care.

The District Court was correct in ruling that the economic impact of the provider tax is tenuous, remote and peripheral, and therefore this factor weighs against a finding of preemption.

EXERCISE OF TRADITIONAL STATE POWER

The passage of MinnesotaCare was an exercise of the state's inherent police powers in the area of health care, in which states have traditionally enacted statutes, as Judge Magnuson noted. Boyle, at 1317. As Justice Blackmun wrote for the Court in Metropolitan, "The States traditionally have had great latitude under their police powers to legislate as to 'the protection of the lives, limbs, health, comfort, and quiet of all persons.'" Metropolitan, 471 U.S., at 756, 105 S.Ct., at 2397 (citing Slaughter-House Cases, 16 Wall, 36, 62, 21 L.Ed. 394 (1873). Judge Magnuson did not find that this factor weighed either for or against preemption, for he cited the statement in Arkansas BCBS in which this Court stated that it was not convinced that the traditional nature of a state's exercise of authority properly bears on the question of whether a state statute "relates to" ERISA plans. Arkansas BCBS, at 1350. In making this statement, the Court observed that "Although the Supreme Court has not discussed the relevance of this factor, its failure to consider this criterion when deciding ERISA preemption cases is telling." (citing Mackey, supra, and FMC Corp. v. Holliday, supra.) Id. In Travelers, however, the Supreme Court did mention this factor, stating that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern. See Hillsborough County v. Automated

Medical Laboratories, Inc., 471 U.S. 707, 719, 105 S.Ct. 2371, 2378, 85 L.Ed.2d 714 (1985); 1 B. Furrow, T. Greaney, S. Johnson, T. Jost, & R. Schwartz, Health Law, Sections 1-6, 1-23 (1995)." Travelers, at 1680. In another passage Justice Souter wrote that the surcharges in the New York statute indirectly affected relative prices of insurance policies, a result "no different from myriad state laws in areas traditionally subject to local regulation," which Congress did not intend to eliminate. Id. at 1683. After Travelers, apparently the exercise of traditional state power is clearly a factor that is relevant to the preemption analysis. Moreover, in Metropolitan, supra, the Supreme Court had stated that "We also must presume that Congress did not intend to preempt areas of traditional state regulation." Metropolitan, 471 U.S., at 2389. It is not necessary, however, to rely upon this factor in order to reject the preemption challenge in the instant case, since all the other factors clearly weigh against preemption.[7]

The factors of economic impact, effect on primary ERISA entities and impact on plan structure, whether the statute negates a plan provision or relates to other ERISA statutory provisions, and impact on administration of ERISA plans, clearly lead to the conclusion that MinnesotaCare has only a tenuous, remote and peripheral affect on the plans. ERISA does not preempt the provider tax.

LABOR MANAGEMENT RELATIONS ACT

Appellants contend that the provider tax conflicts with the Labor Management Relations Act (the LMRA or the Taft-

[7] The Arkansas BCBS Court acknowledged that the exercise of traditional state power "arguably is a policy consideration useful in deciding borderline questions of ERISA preemption." Arkansas BCBS, at 1350. Since this case does not present a borderline ERISA preemption question, it is not necessary to discuss policy considerations in this context.

Hartley Act of 1947), 29 U.S.C. 141 et seq., and is thus preempted by the Supremacy Clause of the United States Constitution. The section of the LMRA at issue is a criminal statute generally prohibiting employers from giving money or other valuable items to representatives of their employees. 29 U.S.C. 186. The statute contains an exception providing that contributions paid for health care benefits on behalf of employees under collective bargaining agreements must be held in trust for the exclusive benefit of the employees, their families, and dependents. 29 U.S.C. 186(c)(5). Appellants assert that the MinnesotaCare provider tax violates the exclusive benefits provision of LMRA by requiring them to pay higher costs in order to benefit people who are not plan participants.

Appellants' reliance upon Section 186 is misplaced. In Arroyo v. United States, 359 U.S. 419, 79 S.Ct. 864, 3 L.Ed.2d 915 (1959), the Supreme Court explained the purpose of this section of LMRA: "Those members of Congress who supported [Section 186] were concerned with corruption of collective bargaining through bribery of employee representatives by employers, with extortion by employee representatives, and with the possible abuse by union officers of the power which they might achieve if welfare funds were left to their sole control." The legislative history reveals Congressional intent in passing the legislation. As Senator Taft, the primary author of the LMRA, stated: "Certainly unless we impose some restrictions we shall find that the welfare fund will become merely a war chest for the particular union, and that the employees for whose benefit it is supposed to be established, for certain definite welfare purposes, will have no legal rights and will not receive the kind of benefits to which they are entitled after such deductions from their wages." 93 Cong.Rec. 4877 (1947), 2 Leg.Hist.LMRA, at 1312. Congress believed that if welfare funds were established that did not provide specific definitions

of the benefits that were payable under them, "a substantial danger existed that such funds might be employed to perpetuate control of union officers, for political purposes, or even for personal gain." Arroyo, at 425-426. This Court cited the above quotation from Arroyo in making clear that the Congressional objective in passing the LMRA was in "keeping large sums of employee-earned money out of the sole control of union officers" in order to prevent corruption or possible abuses of power by union officers for political purposes or personal gain. Master Insulators of St. Louis v. Local No. 1, 925 F.2d 118, 1121 (8th Cir. 1991). The District Court aptly cited a more recent Supreme Court decision following Arroyo in United Mine Workers of America Health & Retirement Funds v. Robinson, 455 U.S. 562, 102 S.Ct. 1226, 71 L.Ed.2d 419 (1982). In United Mine Workers, Justice Stevens stressed that Section 186 was intended to "protect employees from the risk that funds contributed by their employers for the benefit of the employees and their families might be diverted to other union purposes or even to the private benefit of faithless union leaders." United Mine Workers, 455 U.S., at 571-572, 102 S.Ct., at 1231. Supporters of the LMRA exclusive benefits provision were concerned that pension funds that were administered solely by union leaders might serve as war chests for union programs or political factions, or they might become instruments through which "'racketeers' accepted bribes or extorted money from employers." Id.

The District Court rejected the argument that Section 186 denied states power to enact laws such as the provider tax, with its "only tangential impact on employee benefit plans." Boyle, at 1317. Appellants have not cited any cases in which Section 186 preempted a state law that imposed a tax or increased costs that were passed on to an employee trust fund. This section was clearly intended to prevent the use of employee contributions for personal or political war chests, or instruments for bribery or extortion. The MinnesotaCare law

in no way obstructs the objectives of Section 186. To the extent that appellants' argument regarding the LMRA exclusive benefits provision is similar to its argument based on the ERISA exclusive benefits provision, the Court rejects that view for the reasons discussed in previous sections of this opinion. Just as the provider tax does not violate ERISA's requirement that plan funds be held for the exclusive purposes of providing benefits to plan participants, it does not violate the LMRA's requirement that the funds be maintained for the exclusive benefit of the employees. The District Court was correct in its conclusion that Section 186 is not in conflict with the LMRA.

Appellees assert that appellants have impermissibly raised a new issue on appeal concerning National Labor Relations Act (NLRA) preemption, citing the rule stated in Hinton v. CPC International, Inc., 520 F.2d 1312, 1314 (8th Cir1975)("It is well settled law that issues not raised in the trial court cannot be considered by an appellate court as a basis for reversal."). Appellants reply that the LMRA is an amendment to the National Labor Relations Act, with the two acts comprising fundamental components of "what we know as our National Labor Law." (Appellants' reply brief, at 19). Moreover, it is uncertain that plaintiffs had standing to present this claim, because they are not the unions that could hypothetically be injured under the NLRA claim; plaintiffs are the trustees of the ERISA plans funded by union members and their employers. Even assuming, arguendo, that appellants have standing and that they are not raising a new issue on appeal, the NLRA argument still does not present a valid argument for preemption.

In their NLRA argument, appellees rely primarily upon Golden State Transit Corporation v. City of Los Angeles, 475 U.S. 608, 106 S.Ct. 1395, 89 L.Ed.2d 616 (1986), in which the Supreme Court held that the NLRA preempted the City of Los Angeles' action in conditioning the renewal of a taxicab

franchise renewal on the cab company's settlement of a labor dispute. The Golden State Court ruled that Los Angeles had intruded into the collective bargaining process to the extent of becoming a party to the negotiations. Id., at 619, 106 S.Ct. 1401. Appellants contend that the unions will negotiate different terms in their next collective bargaining agreements in response to the provider tax. Appellees are correct that the MinnesotaCare provider tax does not inject the State into collective bargaining or otherwise involve the degree of state intrusion involved in Golden State, in which the Court stressed that the Los Angeles City Council's settlement condition "destroyed the balance of power designed by Congress, and frustrated Congress' decision to leave open the use of economic weapons." Id. (emphasis added).

Appellants also cite Hydrostorage v. Northern California Boilermakers Local Joint Apprenticeship Committee, 685 F.Supp. 718 (N.D. Cal. 1988), aff'd, 891 F.2d 719 (9th Cir. 1989), cert. denied, 498 U.S. 822 (1990)(the Ninth Circuit did not reach the NLRA preemption question because it affirmed on other grounds). In Hydrostorage, the District Court ruled that a state order requiring an employer to enter into a collective bargaining agreement to train apprentices was preempted by the NLRA. The District Court relied upon Golden State in holding that the State could not penalize an employer for not becoming a party to a collective bargaining agreement that it did not voluntarily negotiate. Hydrostorage, 685 F.Supp., at 725. The State was "intruding into the area of collective bargaining from which Congress under the NLRA excluded it... 'The NLRA requires an employer and a union to bargain in good faith, but it does not require them to reach an agreement.'" Id., citing Golden State, at 616, 106 S.Ct. at 1399-1400. The law at issue in the instant case provides a contrast to the order in Hydrostorage, for MinnesotaCare does not penalize anyone for refusing to agree to specific contract terms.

Appellant has not stated any valid basis upon which the NLRA could preempt a state law that imposes a 2 percent tax that will ultimately be passed along to some degree to an ERISA plan. :In Metropolitan, supra, the Supreme Court upheld against both ERISA and NLRA preemption challenges a Massachusetts statute that required certain minimum mental health care benefits be provided a person under general insurance policies; the statute was designed in part to insure that people who were not wealthy could obtain adequate mental health care treatment should they require it. 471 U.S., at 758, 105 S.Ct., at 2399. Justice Blackmun acknowledged in Metropolitan that the state statute forced the parties to the collective bargaining agreement to make a choice: "either they must purchase the mandated benefit, decide not to provide health coverage at all, or decide to become self-insured, assuming they are in a financial position to make that choice." Id., at 748, 105 S.Ct., at 2393. The mandated benefit law was not preempted by NLRA, despite the fact that it may affect substantive benefits available for collective bargaining.

The provider tax does not present the state interference and compulsion present in Golden State and Hydrostorage. The District Court's analysis of United Miné Workers was correct. There is no preemption under labor law.

CONCLUSION

The District Court was correct in holding that appellants did not have standing to challenge the data reporting and spending cap provisions of the statute. The MinnesotaCare provider tax is not preempted by ERISA or the LMRA. The District Court is affirmed.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT

3RD CASE of Level 1 printed in FULL format.

PATRICK BOYLE, JAMES DAUGHERTY, THOMAS R. FRANTES, P. DAN GILBERT, CHARLES MALONEY, THOMAS MARTIN ROBERT SCHWARTZBAUER, and GARY THADEN, as the Board of Trustees of the Twin City Pipe Trades Welfare Trust, et al., Plaintiffs, v. MORRIS ANDERSON, in his capacity as the Commissioner of the Minnesota Department of Revenue, et al., Defendants.

Civ. File No. 3-93-359

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MINNESOTA, THIRD DIVISION

849 F. Supp. 1307; 1994 U.S. Dist. LEXIS 4931; 128 Lab. Cas. (CCH) P57,682; 18 E.B.C. 1363

April 12, 1994, Decided

JUDGES: [**1] Magnuson

OPINIONBY: PAUL A. MAGNUSON

OPINION: [*1309] MEMORANDUM AND ORDER

I. INTRODUCTION

This matter is before the Court upon Plaintiffs' Motion for Summary Judgment. Asserting that there are no genuine issues of material fact, Plaintiffs move for summary judgment and ask this Court for a permanent injunction barring the State of Minnesota from enforcing certain provisions of Minnesota statutes with respect to Plaintiffs. Defendants agree that there

are no genuine issues of material fact in this matter and request that summary judgment be granted in favor of Defendants. For the following reasons, the Court enters summary judgment in favor of Defendants. n1

> n1 Summary judgment may be granted in favor of a nomnoving party. See *Hvamstad v. Suhler, 727 F. Supp. 511, 520 (D. Minn. 1989)*, aff'd, *915 F.2d 1218 (8th Cir. 1990)*; see also *Celotex Corp. v. Catrett 477 U.S. 317, 326, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986)* ("District courts are widely acknowledged to possess the power to enter summary judgments sua sponte, so long as the losing party was on notice that she had to come forward with all of her evidence.")

[**2]

II. BACKGROUND

The Minnesota Legislature enacted the Minnesota Health Right Act, now commonly known as MinnesotaCare, in April of 1992. In passing this law, legislators sought to reduce health care costs and to make health care available for all Minnesotans. Plaintiffs in this case include the trustees of thirteen welfare benefit plans ("Plans") that provide health care benefits for a large number of individuals, primarily union members and their dependents. The Plans were created and operate under the provisions relating to welfare benefit plans in the Employee Retirement Income Security Act of 1974 (ERISA), *29 U.S.C. § 1001*, et seq. They are funded through contributions by the covered workers and their employers. (Pltfs.' Memo. Supp. Summ. J. at 2.) Plaintiffs brought this action seeking a declaratory-judgment that portions of MinnesotaCare are preempted by ERISA and the Labor Management Relations Act (LMRA), *29 U.S.C. § 141*, et seq.

Plaintiffs present three main arguments in support of their Motion for Summary Judgment. First, the Plaintiffs challenge collection and reporting provisions of the Minnesota [**3] Care Act on the grounds that those provisions are preempted by ERISA. Second, they contend that the spending caps set forth in the act are also preempted by ERISA. Plaintiffs' primary challenge to the statute, however, centers around a two percent provider tax. They argue that the provider tax is preempted by ERISA and LMRA insofar [*1310] as that tax is passed on to health benefit plans covered by those federal statutes.

The provider tax, while not the only means of funding the Minnesota Care programs, n2 is the only tax challenged by the Plaintiffs in this case. The tax is passed through from hospitals and other health care providers to third parties in two ways. First, under the statute, a provider is permitted to transfer the two percent tax to third-party purchasers, including employee benefit plans such as Plaintiffs. The provision states as follows:

A hospital, surgical center, pharmacy, or health care provider that is subject to a tax under section 295.52 may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. The expense must not exceed two percent of the [**4] gross revenues received under the third-party contract, including copayments and deductibles paid by the individual patient or consumer. . . . All thirdparty purchasers of health care services . . . must pay the transferred expense in addition to any payments due under existing or future contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. Nothing in this subdivision limits the ability of a hospital, surgical center, pharmacy, or health care provider to

recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

Minn. Stat. § 295.582 (Supp. 1993).

n2 Among the sources of funding for the Minnesota Care law are a cigarette tax increase and a two percent tax on gross revenues of hospitals, surgical centers, pharmacies and wholesale drug distributons. Ch. 549. 1992 Minn. Laws 1616-17; Minn. Stat. § 295.52.

As suggested by the last sentence in this provision, the second way in which providers may pass [**5] the two percent tax through to third parties is by increasing their overall charges for health care services. Under this method, third-party purchasers do not receive a separate itemized charge for the provider tax. They are, however, forced to pay higher amounts for the services than they would have before the passage of Minnesota Care. (Pltfs.' Memo. Supp. Summ. J. at 7-8; Defs.' Memo. Opp. Summ. J. at 4-5.)

III. DISCUSSION

Summary judgment is appropriate if there is no genuine issue of material fact and a party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett, 477 U.S. 317, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986); Unigroup, Inc. v. O'Rourke Storage & Transfer Co, 980 F.2d 1217, 1219-20 (8th Cir. 1992).* As the Supreme Court has stated, "summary judgment procedure is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole." *Celotex, 477 U.S. at 327.*

A. ERISA Claims

In passing ERISA, Congress sought to free employee [**6] benefit plans from conflicting regulations by different states. ERISA contains broad preemption provisions which are designed to provide a single uniform set of regulations for the administration of employee benefit plans. See *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9, 107 S. Ct. 2211, 2216, 96 L. Ed. 2d 1* (1987). The statute reads as follows: "The provisions of this subchapter . . . shall supersede any and all State laws insofar as they may not or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." *29 U.S.C. § 1144*(a). In interpreting this provision, the Supreme Court has held that the phrase "relate to" should be "construed expansively." *Id. at 8.*

Notwithstanding this broad interpretation of the statute, however, the Supreme Court has "recognized limits to ERISA's pre-emption clause." *Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139, 111 S. Ct. 478, 483, 112 L. Ed. 2d 474 (1990).* [**7] For example, in *Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 108 S. Ct. 2182, 100 L. Ed. 2d 836 (1988),* the Supreme Court held that the clause did not preempt a state general garnishment statute, and in *Fort Halifax, 482 U.S. at 19, 107 S. Ct. at 2221,* it determined that a state severance pay statute [*1311] was not preempted by ERISA. "ERISA pre-emption analysis must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.'" Id. (quoting *Alessi v Raybestos-Manhattan, Inc., 451 U.S. 504, 522, 101 S. Ct. 1895, 1905, 68 L. Ed. 2d 402 (1931)).* There is a general presumption that "Congress did not intend for ERISA to preempt areas of traditional state regulation." *Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740, 105 S. Ct. 2380, 2389, 85 L. Ed. 2d 728 (1985).* The Supreme Court

that indicated that ERISA does not preempt a generally applicable statute that makes no reference [**8] to, or indeed functions irrespective of, the existence of an ERISA plan." Id. It has also noted that "some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21, 103 S. Ct. 2890, 2901 n.21, 77 L. Ed. 2d 490 (1983).*

1. Data Collection and Reporting

The Plaintiffs argue first that the data collection and reporting provisions of the Minnesota Care Law are preempted by ERISA because "they represent direct regulation of Plaintiffs' plans." (Pltfs.' Memo. Supp. Summ. J. at 15.) The reporting requirements are found in Minn. Stat. §§ 62J.35 and 62J.38. Section 62J.35 provides that "the commissioner [of the Minnesota Department of Health] may collect from health care providers data on patient revenues and health care spending during a time period specified by the commissioner." Section 62J.38 states that "the commissioner shall require group purchasers to submit detailed data on total health care spending . . . ." To implement these provisions the Commissioner promulgated [**9] emergency rules regarding the data collection and reporting requirements. Minn. R. pt. 4652.0110 provides, in pertinent part, as follows:

The following group purchasers, as defined under part 4652.0100 [Emergency], subpart 14 are subject to the reporting requirements established by part 4652.0120 [Emergency]: all insurance companies . . . that reported $ 10,000 or more in total health premiums to the Department of Commerce in 1991 and all health service plan corporations . . . . Employee health plans offered by self-insured employers

will be encouraged to comply with these reporting requirements.

As the statute is currently enforced, therefore, the Plaintiffs are not required to submit health care revenue and expenditure data; they are merely "encouraged" to do so.

In response, the Defendants argue that, because the Plaintiffs "are not compelled by the statute or rule to provide any data, " there is "nothing to preempt." (Defs.' Memo. Opp. Summ. J. at 11.) Plaintiffs assert that "if the State does not intend to seek such information from the plaintiffs, the State should not oppose an injunction which makes clear that the collection of such information is preempted by ERISA." (Pltfs.' [**10] Reply Memo. Supp. Summ. J. at 4.)

Plaintiffs' challenge to the data reporting provisions has two flaws. First, Plaintiffs do not have standing to challenge the statute and rule. As the Supreme Court stated in *Lujan v. Defenders of Wildlife, 119 L. Ed. 2d 351, 112 S. Ct. 2130, 2136 (1992),* a plaintiff must satisfy three elements to establish standing.

First, the plaintiff must have suffered an "injury in fact" -- an invasion of a legally-protected interest which is (a) concrete and particularized . . . and (b) "actual or imminent, not 'conjectural' or 'hypothetical.'" . . . Second, there must be a causal connection between the injury and the conduct complained of . . . . Third, it must be "likely" . . . that the injury will be "redressed by favorable decision."

The Plaintiffs bear the burden of proof on each of these elements, and the elements are an "indispensable part of the plaintiff[s'] case." Id. Where plaintiffs challenge a governmental regulation of others but are not themselves subject to such regulation, "standing is not precluded, but it is

ordinarily 'substantially more difficult' to establish." *112 S. Ct. at 2137*. In [**11] the instant case, Plaintiffs have failed to show that they are in any way injured by the reporting requirements of Minnesota Care, which do not apply to these Plaintiffs. Because they have not met the first element of [*1312] the constitutional requirements of standing, Plaintiffs have failed to meet their burden on the issue of reporting data.

The second flaw in Plaintiffs' argument is that they are effectively asking this Court to render an advisory opinion on this issue. The fact that the State might at some future point revise the reporting requirements to make them applicable to the Plaintiffs does not present a justiciable issue for this Court. "'The oldest and most consistent thread in the federal law of justiciability is that the federal courts will not give advisory opinions.'" *Flast v. Cohen, 392 U.S. 83, 96-97, 88 S. Ct. 1942, 1950-51, 20 L. Ed. 2d 947 (1968)* (quoting C. Wright, the Federal Courts 34 (1963)).

Because Plaintiffs have failed to demonstrate that they have standing to challenge the data reporting requirements of Minnesota Care, their challenge to those provisions must fail. Accordingly, summary judgment is [**12] granted in favor of Defendants on the issue of data reporting requirements.

2. Spending Cap Provisions

Similar problems arise in connection with the Plaintiffs' arguments against the spending cap provisions of Minnesota Care, which apply to "health carriers." Minn. Stat. § 62P.04 (Supp. 1993). Because Plaintiffs are not within the statutory definition of "health carriers," see Minn. Stat. § 62A.011 (Supp. 1993), they are not subject to the regulation limiting increases in costs. Thus, there is no basis for Plaintiffs' claim that "to the extent that the Trust is required to comply with spending caps imposed by the Minnesota Care legislation, The

Plan would have to monitor claims expenses during a calendar year to forecast whether claims expense will potentially exceed the amount authorized by statute." (Pltfs.' Memo. Supp. Summ. J. at 15.) The Plaintiffs are not required to comply with the spending caps to any extent.

As with the data reporting requirements, Plaintiffs are unable to show an injury in fact resulting from the spending cap provisions. Because Plaintiffs have again failed to establish the elements of standing discussed above, summary judgment is granted in [**13] favor of Defendants on the issue of the spending cap provisions of Minnesota Care.

3. Provider Tax

Plaintiffs' primary claim relates to the provider tax under Minnesota Care. According to Plaintiffs, the provider tax is preempted by ERISA insofar as that tax is passed through to the Plans. n3 Because the Plaintiffs have shown injury in fact that is caused by the statute and that could be redressed by a decision in their favor, they have met the minimum constitutional requirements for standing. See *Lujan, 112 S. Ct. at 2136.*

n3 Defendants argue that there is no state action with respect to the "non-statutory passthrough" of the provider tax. (Defs.' Memo. Opp. Summ. J. at 12-13.) Because ERISA's preemption clause on its Face extends to both direct and indirect regulation by the State, *29 U.S.C. § 1144*(a) and (c), the Court is convinced that there is sufficient state action for the Court to reach the issue of ERISA preemption. The Court also notes that Plaintiffs' claims are not barred by the Tax Injunction Act, *28 U.S.C. § 1341* (1988). See *The Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 713-14 (2d Cir. 1993)* (ERISA confers exclusive jurisdiction on Federal courts).

[**14]

Turning to the merits, the Court must determine whether the provisions of Minnesota Care that impose the provider tax "relate to" the Plaintiffs' employee benefit plans and are thus within the scope of ERISA's preemption clause. In *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., 947 F.2d 1341, 1344-45 (8th Cir. 1991)* [hereinafier Arkansas BCBS], the Eighth Circuit listed a number of factors to be considered when determining whether a state statute of general application is preempted by ERISA. Those factors are as follows: 1) whether the state law negates a provision of an ERISA plan, 2) whether the state law affects relations between primary ERISA entities, 3) whether the state law has an impact on the structure of ERISA plans, 4) whether the state law has an impact on the administration of ERISA plans, 5) whether the state law has an economic impact on ERISA plans, 6) whether preemption of the state law is consistent with other ERISA provisions, and 7) whether the State law is an exercise of traditional state power. Id.

[*1313] Before applying the Arkansas BCBS factors, the Court must determine whether the statute is one of "general [**15] application." "For ERISA purposes, a law of general applicability is one which does not treat ERISA plans differently from non-ERISA plans." *New England Health Care Employees Union Dist. 1199 v. Mount Sinai Hosp., 846 F. Supp. 190, 1994 U.S. Dist. LEXIS 2181,* at *25 n.11 (D. Conn. Feb. 25, 1994). Courts have held that statutes that do not explicitly refer to a benefit plan are statutes of general application. Minnesota Ch. Ass'd Bldrs. & Contrs. v. Minnesota Dept. Labor & Indus., et al., Civ. No. 4-92-564, slip op. at 4 (D. Minn. Nov. 1, 1993); NYSA-ILA Medical & Clinical Serv. Fund v. Axelrod, No. 92 Civ. 2779, 1993 WL 51146, at *3 (S.D.N.Y. Feb. 23, 1993). Minnesota Care's provider tax does not apply to ERISA plans differently than

non-ERISA plans. The statute does not explicitly refer to ERISA plans or apply primarily to such plans; it applies to all health care providers, and the passthrough of the tax potentially affects all third-party purchasers. Therefore, the statute is one of general application, and the Arkansas BCBS factors are relevant.

a. Negation of a Plan Provision and Relation to Other ERISA Statutory Provisions

First, [**16] the Court considers whether Minnesota Care's provider tax negates a plan provision or relates to other ERISA statutory provisions. A state statute that negates a plan provision may be found to be preempted by ERISA. *Arkansas BCBS, 947 F.2d at 1345.* Plaintiffs contend that, by raising costs to the Plans, the provider tax contravenes provisions of the plan as well as a provision of ERISA itself. *29 U.S.C § 1103(c)(1)* provides that "the assets of a plan . . . shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries." According to Plaintiffs, the Minnesota Care Law increases costs to employee benefit plans in order to provide benefits to uninsured individuals who are not beneficiaries of the plans and thus violates the "exclusive benefits' provision of ERISA.

Plaintiffs' argument stretches ERISA's exclusive benefit provision beyond the bounds intended by Congress. Section 1103(c)(1), along with other sections such as *29 U.S.C. § 1104*(a), sets forth a number of fiduciary duties for plan administrators and employers. Congress [**17] did not include these provisions in order to limit the costs to plans under ERISA; it included these provisions in order to make the law of trusts applicable to the plans and to eliminate "such abuses as self-dealing, imprudent investing, and misappropriation of plan funds." n4 Congress was not

concerned with whether persons not covered by ERISA plans were somehow benefitted by the operation of those plans.

n4 *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 15, 107 S. Ct. 2211, 2219, 96 L. Ed. 2d 1.* Senator Williams made the following remarks in discussing the Conference Report on ERISA in 1974:

> Despite the value of full reporting and disclosure, it has become clear that such provisions are not in themselves sufficient to safeguard employee benefit plan assets from such abuses as self-dealing, imprudent investing, and misappropriation of plan funds. . . . Accordingly, the legislation imposes strict fiduciary obligations on those who have discretion or responsibility respecting the management, handling, or disposition of pension or welfare plan assets. The objectives of these provisions are to make applicable the law of trusts; to prohibit exculpatory clauses that have often been used in this field; to establish uniform fiduciary standards to prevent transactions which dissipate or endanger plan assets; and to provide effective remedies for breaches of trust.
>
> 120 Cong. Rec. 29.932 (1974).

[**18]

In *United Wire, Metal and Mach, Health & Welfare Fund v. Morristown Memorial Hospital, 995 F.2d 1179 (3d Cir. 1993)*, the parties arguing in favor of preemption raised a similar argument regarding the exclusive benefits provisions of ERISA. The Third Circuit refused to accept the argument, stating,

There are many forms of state regulation under the police power which result in increases in the cost of doing business and corresponding increases in prices where the beneficiaries of the regulation are not those who are paying the increased prices. States have recently begun to regulate the disposal of medical wastes, for example, in order to protect those who would otherwise be adversely affected by socially irresponsible [*1314] disposal. Such regulations can significantly increase a hospital's cost of doing business and, accordingly, its billings to plan participants. We are confident, however, that ERISA was not intended to foreclose a state regulation of this kind. *Id. at 1196.* The court also held that evidence regarding congressional intent did not support Plaintiffs' argument: "In short if ERISA is held to invalidate every [**19] State action that may increase the cost of operating employee benefit plans, those plans will be perinitted a charmed existence that never was contemplated by Congress." *Id. at 1194.*

Because the provider tax does not negate a plan provision or conflict with other ERISA statutory provisions, these factors do not favor a finding of preemption.

b. Effect on Primary ERISA Entities and Impact on Plan Structure

Next, the Court considers the statute's effect on primary ERISA entities and impact on plan structure. The Eighth Circuit treats these two factors as identical. *Arkansas BCBS, 947 F.2d at 1346.* If the state law alters the relationships among the primary ERISA entities -- the employer, the plan, the plan fiduciaries, and the beneficiaries -- and thereby alters the structure of the plan, this factor weighs in favor of preemption. In Arkansas BCBS, the court found that this factor "strongly supported a finding that the [Arkansas] assignment statute 'related to' ERISA plans." The statute in

that case significantly altered the plan structure by transferring the power to determine who could receive benefits under [**20] a plan from a plan fiduciary to plan beneficiaries. In this way, the statute had an effect on the relationships between primary ERISA entities that was "not a 'tenuous' impact on the plan." Id.

Unlike the Arkansas assignment statute, MinnesotaCare's provider tax does not alter the relationships between primary ERISA entities in any way. As Defendants point out. "None of the plans who have answered [Defendants' interrogatories] have identified any changes in the plan documents or any other effect on plan structure or relationships in order to comply with the passthrough [of the provider tax.]" (Defls.' Memo. Opp. Summ. J. at 26 n. 15.)

Plaintiffs again assert that their "exclusive benefits" theory shows that the provider tax impacts plan structure. Because persons who are not plan beneficiaries receive benefits through the provider tax, Plaintiffs argue, those persons are effectively added as new beneficiaries to the plans. As discussed above, see supra part III.A.3.a, the exclusive benefits provision does not mean that every indirect benefit to persons other than plan beneficiaries is prohibited by ERISA. To say that these persons are converted into "beneficiaries" of the [**21] plans in some technical sense is overstating the case. n5 Such an interpretation would lead to the conclusion that every state law that results in any increased cost to a plan, such as a sales tax, environmental regulations, or minimum wage laws, are preempted by ERISA. Congress did not intend that ERISA would prevent states from passing laws that would have this type of minimal effect on plan structure.

n5 This Court declines to follow the decision of the United States District Court for the Eastern District of Louisiana in *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Ass'n, 771 F. Supp. 771 (E.D. La.*

1991). First, that case applied Fifth Circuit rather than Eighth Circuit law. Second, the statute challenged in Bricklayers required hospitals to impose additional charges rather than merely permitting them to do so.

Because the provider tax does not have any significant effect on primary ERISA entities, this factor does not support a finding of preemption.

c. Impact [**22] on Administration of Plan

In Arkansas BCBS, the court found that the state assignment statute directly impacted both intrastate and interstate administration of ERISA plans. "By giving the plan beneficiaries sole control of assignments, the assignment statute imposes on the claims administrator the burden of determining whether and to whom the plan beneficiaries have made assignments and then paying the appropriate parties." *947 F.2d at 1346-47.*

The MinnesotaCare provider tax, by contrast, does not impose an administrative burden. First, there is no significant intrastate impact. Plan administrators do not have to consider claims on an individual basis in order [*1315] to determine the proper payee. Defendants point out that,

None of the . . . Plaintiffs identified any additional administrative actions taken or costs incurred as a result of the passthrough of the provider taxes. The only administrative inefficiency noted was that in the rare instances of hospitals that submit a separate billing for the provider tax, an extra administrative cost is incurred in processing that additional payment.

(Defs.' Memo. Opp. Summ. J. at 29.) The typical methods [**23] of passing through the provider tax are "including it in

increased charges or by adding the passthrough as a separate item on the hospital bill." (Id.) Neither of these methods can be viewed as a significant burden on plan administrators. Thus, the provider tax does not impact intrastate administration.

Second, the provider tax does not affect interstate administration. Plaintiffs contend that there is an interstate impact because the plans will have beneficiaries in Minnesota who will be subject to the tax and others who will not be in Minnesota and therefore will not be subject to the tax. This minor difference in cost is not the type of impact found in Arkansas BCBS. There, the Arkansas assignment statute possibly could conflict with assignment statutes in other states, thereby requiring plan administrators to undertake detailed analysis with respect to each claim in order to resolve the claim properly. 947 *F.2d at 1348.* Here, no such potential conflict exists. Plan administrators need not be concerned about conflicting state laws.

Once again, Plaintiffs' responses to interrogatories do not support their allegations of impact on plan administration. [**24] Plaintiffs admit that their plans are presently equipped to accommodate differences in costs for similar procedures. They also concede that the amounts they pay for similar services at different locations can vary by more than two percent. (Defs.' Memo. Opp. Summ. J. at 30.) In addition to Plaintiffs' answers, independent sources have reported significant differentials in price for similar procedures both within Minnesota and in comparison with other states. See Wis. Dept. Health & Soc. Serv., Health Care Data Report, Annual Report, Hospital Utilization and Charges in Wisconsin, January-December 1990 (1991); Council of Hospital Corporations, Revised Hospital Charges By Diagnosis Related Group (1990).

Because the provider tax as it is passed through to plans does not pose significant additional difficulties for either intrastate or interstate administration of ERISA plans, the Court finds that this factor does not support a finding of preemption.

d. Economic Impact

The Arkansas BCBS court found the economic impact of a state statute on a plan to be "highly relevant to whether the . . . statute 'relates to' ERISA plans." *947 F.2d at 1348.* [**25] At the same time, the court "agreed that 'tenuous, remote, and peripheral' economic impact on ERISA plans, in itself, is not sufficient to find preemption." Id.

Recent decisions in other circuits have reached differing conclusions regarding the importance of economic impact as a factor in ERISA preemption analysis. In *E-Systems, Inc. v. Pogue, 929 F.2d 1100 (5th Cir. 1991),* the Fifth Circuit stated that the economic impact of a state law on a plan could by itself warrant a finding of preemption. Similarly, the Second Circuit concluded in *The Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 721 (2d Cir. 1993),* that a state statute that imposes "a significant economic burden" on ERISA plans "relates to" ERISA and is therefore preempted. The Third Circuit, by contrast, held in *United Wire, Metal, & Machine Health & Welfare Fund v. Morristown Memorial Hospital, 995 F.2d 1179* (3d Cir.), cert. denied, *114 S. Ct. 382 (1993),* that economic impact by itself is not sufficient to warrant a finding of preemption. Plaintiffs ask this Court to follow the Fifth and Second [**26] Circuits rather than the Third.

For several reasons, this Court is not persuaded that the Travelers and E-Systems decisions require a finding of preemption in this case. As Judge Cabranes noted in New England Health Care Employees Union Dist. 1199 v. Mount Sinai Hosp., No. 2:92-*CV-1012, 1994 U.S. Dist. LEXIS 2181,*

at *22-23 (D. Conn. Feb. 25, 1994), "the Travelers court acknowledged that where the economic impact of a generally applicable state statute is 'de minimis,' the statute will [*1316] avoid ERISA preemption. . . . In sum, under Travelers, an economic impact which is insufficient to affect the structure or administration of ERISA plans is insufficient to trigger ERISA preemption." As discussed above, the MinnesotaCare provider tax does not alter the structure or administration of ERISA plans. Therefore, even under the Travelers analysis, the statute is not preempted by ERISA.

Both the E-Systems and Travelers cases involved significantly different facts from the case at bar. In E-Systems, the challenged Texas statute applied an annual tax on each person "receiving any form of administrative or service fee, consideration, [**27] payment, premium, fund reimbursement, or compensation' for providing a service for [certain enumerated plans.]" *929 F.2d at 1101.* The plans specifically listed in the statute were "virtually identical to those covered by ERISA." Id. Thus, the Texas law 'related to' ERISA plans on its face and had a significant economic impact on ERISA plans. In contrast, the MinnesotaCare provider tax does not involve this direct taxation on services offered by ERISA plans.

Travelers also is distinguishable because the economic impact in that case was much greater than the small provider tax in this case. Under the New York statute in Travelers, ERISA plans faced significant surcharges of thirteen, eleven, and nine percent. *14 F.3d at 713.* The Second Circuit drew upon the reasoning of NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod, No. 92 Civ. 2779, 1993 Westlaw 51146 (S.D.N.Y. Feb. 23, 1993), in which the "court recognized that a substantial economic impact, standing alone, could be enough to bring ERISA's preemption clause into play." *Travelers, 14 F.3d at 720-21* (citing NYSA-ILA, 1993 [**28] Westlaw 51146 at *4) Because the instant case does not

involve "substantial economic impact, " the Travelers rationale is not determinative.

The decision of the Third Circuit in United Wire, however, is on point. In that case, a number of self-insured employee benefit plans argued that ERISA preempted a New Jersey statutory and regulatory scheme aimed at reducing health costs. *995 F.2d at 1188-89.* The court stated as follows:

New Jersey's scheme may increase the charges billed to ERISA plan participants For hospital services. This will mean that any plan which commits to pay all or some lesser percentage of a participant's hospital costs will be called upon to pay more in benefits than it otherwise would. This effect is not different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e., utility costs, the wages of its employees, waste disposal costs, etc. New Jersey's scheme does not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way. Nor does it deprive ERISA plans of any alternative they would otherwise [**29] have in these areas. Finally, since the cost of hospital services will necessarily vary from region to region, we fail to see how state regulation of hospital pricing like that chosen by New Jersey is likely to make interstate operation of an ERISA plan more difficult.

Id. at 1193. For the same reasons given by the Third Circuit in this discussion, which reveals the parallels between the New Jersey statute and the MinnesotaCare law, this Court finds that ERISA does not preempt the statute at issue here.

Plaintiffs contend that United Wire is flawed because the Third Circuit relied upon the earlier Second Circuit case *Rebaldo v. Cuomo, 749 F.2d 133 (2d Cir. 1984),* cert. denied,

472 U.S. 1008, 86 L. Ed. 2d 718, 105 S. Ct. 2702 (1985), which the Second Circuit overruled in Travelers. This criticism is unmeritorious. The Third Circuit was aware of arguments that Rebaldo was "no longer 'good law' in light of the Supreme Court's subsequent decision in *Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990).* [**30] . . ." *995 F.2d at 1194.* It recognized that some of the Rebaldo analysis was rejected by the Supreme Court, yet found that other parts of the "reasoning remained persuasive." Id. Thus, the court only relied upon the portions of Rebaldo that it found convincing despite the Supreme Court's criticism of other aspects of the case.

Even if this Court does not rely on the United Wire decision, the Arkansas BCBS [*1317] decision shows that the Eighth Circuit does not favor a finding of preemption based on that economic impact alone. As the court specifically stated, "We do not believe that any one factor, by itself, is determinative of the ERISA preemption issue before the court today." *Arkansas BCBS. 947 F.2d at 1345.* In the same way, no single factor is determinative on the question of preemption in this case.

The economic impact of the provider tax is one factor to be considered along with others in deciding whether the state statute is preempted by ERISA. Because the Court finds that the economic impact of the provider tax is "tenuous, remote, and peripheral," *id. at 1348,* this factor [**31] does not favor a finding of preemption.

e. Exercise of Traditional State Power

Finally, the Court notes that the passage of the MinnesotaCare Law is an exercise of traditional state power. Under their inherent police powers, states have long enacted statutes regarding health care. "The containment of hospital costs is an exercise of a State's police powers, which should

not be superseded by federal regulations unless that was the clear intent of Congress." *Rebaldo v. Cuomo, 749 F.2d 133, 138 (2d Cir. 1984)*, cert. denied, *472 U.S. 1008, 86 L. Ed. 2d 718, 105 S. Ct. 2702 (1985)*, overruled by *The Travelers Ins. Co. v. Cuomo, 14 F.3d 708 (2d Cir. 1993)*. Nevertheless, the Eighth Circuit stated in Arkansas BCBS that it was not convinced that this factor properly bears on the question of whether a statute is preempted by *ERISA. 947 F.2d at 1350.* Therefore, the Court does not rely on this factor as either favoring or disfavoring a finding of preemption.

In sum, the Arkansas BCBS factors indicate that the MinnesotaCare provider [**32] tax is not preempted by ERISA. Therefore, the Court grants summary judgment in favor of Defendants on this issue.

B. LMRA Claims

Plaintiffs assert that the MinnesotaCare provider tax also conflicts with the Labor Management Relations Act, (LMRA) *29 U.S.C. § 141* et seq. and therefore it is preempted pursuant to the Supremacy Clause. U.S. Const. art. VI, cl. 2. In particular, they rely on *29 U.S.C. § 186*(c)(5), which provides that employers' contributions made on behalf of employees under collective bargaining agreements must be held in trust for the exclusive benefit of the employees, their families, and dependents. The provider tax, Plaintiffs argue, violates this provision by requiring them to pay increased costs in order to benefit persons who are not members of the plan.

Plaintiffs misinterpret the meaning of § 186 of the LMRA. In *United Mine Workers of Am. Health & Retirement Funds v. Robinson, 455 U.S. 562, 102 S. Ct. 1226, 71 L. Ed. 2d 419*, (1982), the Court discussed the reasoning behind the exclusive benefits provision.

The section [**33] was meant to protect employees from the risk that funds contributed by their employers for the benefit of the employees and their families might be diverted to other union purposes or even to the private benefit of faithless union leaders. Proponents of this section were concerned that pension funds administered entirely by union leadership might serve as "war chests" to support union programs or political factions, or might become vehicles through which "racketeers" accepted bribes or extorted money from employers.

Id. at 571-72, 102 S. Ct. at 1232. Plaintiffs cite no cases in which a court held § 186 to preempt any imposition of state taxes or any other state law. As with Plaintiffs arguments on the exclusive benefits provision of ERISA, the Court is unconvinced that the exclusive benefits provision of LMRA should be read to deny states the power to enact statutes such as the provider tax, which have only tangential impact on employee benefit plans. Because the Court does not find the MinnesotaCare law in conflict with the LMRA, summary judgment is granted in favor of Defendants on this issue.

IV. CONCLUSION [**34]

In conclusion, the Court finds that the Plaintiffs do not have standing to challenge the data reporting provisions of the MinnesotaCare statute. The Court does not render a decision as to whether those provisions are preempted by ERISA because such a decision [*1318] would be purely advisory. The Plaintiffs have also failed to show that they have standing on the issue of the spending cap provisions of the statute. Finally, the Court finds that the provider tax portions of the statute are not preempted by ERISA or the LMRA. For all of these reasons, the Court denies Plaintiffs' Motion For Summary Judgment and grants summary judgment in favor of Defendants.

Accordingly, IT IS HEREBY ORDERED THAT:

1. Plaintiffs' Motion For Summary Judgment (Clerk Doc. No. 14) is DENIED; and

2. Summary judgment is GRANTED in favor of Defendants; and

3. The Clerk of Court shall enter judgment as follows:

IT IS ORDERED, ADJUDGED AND DECREED that the Complaint is DISMISSED in its entirety.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: April 12, 1994

Paul A. Magnuson

United States District Court Judge

ARTICLE III

Section 1. The judicial power of the United States shall be vested in one supreme court, and in such inferior courts as the Congress may, from time to time, ordain and establish. The judges, both of the supreme and inferior courts, shall hold their offices during good behavior, and shall, at stated times, receive for their services a compensation which shall not be diminished during their continuance in office.

Sec. 2. The judicial power shall extend to all cases in law and equity, arising under this Constitution, the laws of the United States, and treaties made, or which shall be made under their authority; to all cases affecting ambassadors, other public ministers and consuls; to all cases of admiralty and maritime jurisdiction; to controversies to which the United States shall be a party; to controversies between two or more states, between a state and citizens of another state, between citizens of different states, between citizens of the same state claiming lands under grants of different states, and between a state or the citizens thereof and foreign states, citizens or subjects.

In all cases affecting ambassadors, other public ministers and consuls, and those in which a state shall be party, the supreme court shall have original jurisdiction. In all the other cases before mentioned the supreme court shall have appellate jurisdiction, both as to law and fact, with such exceptions and under such regulations as the Congress shall make.

The trial of all crimes, except in cases of impeachment, shall be by jury, and such trial shall be held in the state where the said crimes shall have been committed; but when not

committed within any state, the trial shall be at such place or places as the Congress may by law have directed.

Sec. 3. Treason against the United States shall consist only in levying war against them, or in adhering to their enemies, giving them aid and comfort. No person shall be convicted of treason unless on the testimony of two witnesses to the same overt act, or on confession in open court.

The Congress shall have power to declare the punishment of treason, but no attainder of treason shall work corruption of blood, or forfeiture, except during the life of the person attained.

ARTICLE VI

All Debts contracted and Engagements entered into, before the Adoption of this Constitution, shall be as valid against the United States under this Constitution, as under the Confederation.

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof, and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

The Senators and Representatives before mentioned, and the Members of the several State Legislatures, and all executive and judicial Officers, both of the United States and of the several States, shall be bound by Oath or Affirmation, to support this Constitution; but no religious Test shall ever be required as a Qualification to any Office or public Trust under the United States.

Relevant Portions of 29 U.S.C. § 1144 (1994)

29 U.S.C. § 1144(a)

Supersedure; effective date

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. § 1144(c)

Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

Relevant Portions of 29 U.S.C. § 1144 (1994)

29 U.S.C. § 1144(b)

Construction and application

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(b)(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(b)(2)(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003 (b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(b)(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(b)(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

Relevant Portions of 29 U.S.C. § 1144 (1994)

29 U.S.C. § 1144(b)

(b)(5)(a) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§393-1 through 393-51).

(b)(5)(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section--

(i) any State law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(b)(5)(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts.

62J.04. Controlling the rate of growth of health care spending

Subdivision 1. Limits on the rate of growth. (a) The commissioner of health shall set annual limits on the rate of growth of public and private spending on health care services for Minnesota residents, as provided in paragraph (b). The limits on growth must be set at levels the commissioner determines to be realistic and achievable but that will reduce the rate of growth in health care spending by at least ten percent per year for the next five years. The commissioner shall set limits on growth based on available data on spending and growth trends, including data from group purchasers, national data on public and private sector health care spending and cost trends, and trend information from other states.

(b) The commissioner shall set the following annual limits on the rate of growth of public and private spending on health care services for Minnesota residents:

(1) for calendar year 1994, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1993 plus 6.5 percentage points;

(2) for calendar year 1995, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1994 plus 5.3 percentage points;

(3) for calendar year 1996, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1995 plus 4.3 percentage points;

(4) for calendar year 1997, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1996 plus 3.4 percentage points; and

(5) for calendar year 1998, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1997 plus 2.6 percentage points.

If the health care financing administration forecast for the total growth in national health expenditures for a calendar year is lower than the rate of growth for the calendar year as specified in clauses (1) to (5), the commissioner shall adopt this forecast as the growth limit for that calendar year. The commissioner shall adjust the growth limit set for calendar year 1995 to recover savings in health care spending required for the period July 1, 1993 to December 31, 1993. The commissioner shall publish:

(1) the projected limits in the State Register by April 15 of the year immediately preceding the year in which the limit will be effective except for the year 1993, in which the limit shall be published by July 1, 1993;

(2) the quarterly change in the regional consumer price index for urban consumers; and

(3) the health care financing administration forecast for total growth in the national health care expenditures. In setting an annual limit, the commissioner is exempt from the rulemaking requirements of chapter 14. The commissioner's decision on an annual limit is not appealable.

Subd. 1a. Adjusted growth limits and enforcement. (a) The commissioner shall publish the final adjusted growth limit in the State Register by January 15 of the year that the expenditure limit is to be in effect. The adjusted limit must reflect the actual regional consumer price index for urban consumers for the previous calendar year, and may deviate from the previously published projected growth limits to

reflect differences between the actual regional consumer price index for urban consumers and the projected consumer price index for urban consumers. The commissioner shall report to the legislature by January 15 of each year on the projected increase in health care expenditures, the implementation of growth limits, and the reduction In the trend in the growth based on the limits imposed.

(b) The commissioner shall enforce limits on growth in spending and revenues for integrated service networks and for the regulated all-payer system. If the commissioner determines that artificial inflation or padding of costs or prices has occurred in anticipation of the Implementation of growth limits, the commissioner may adjust the base year spending totals or growth limits or take other action to reverse the effect of the artificial inflation or padding.

(c) The commissioner shall impose and enforce overall limits on growth in revenues and spending for integrated service networks, with adjustments for changes in enrollment, benefits, severity, and risks. If an integrated service network exceeds a spending limit, the commissioner may reduce future limits on growth in aggregate premium revenues for that integrated service network by up to the amount overspent. If the integrated service network system exceeds a systemwide spending limit, the commissioner may reduce future limits on growth in premium revenues for the integrated service network system by up to the amount overspent.

(d) The commissioner shall set prices, utilization controls, and other requirements for the regulated all-payer system to ensure that the overall costs of this system after adjusting for changes in population, severity, and risk, do not exceed the growth limits. If spending growth limits for a calendar year are exceeded, the commissioner may reduce reimbursement rates or otherwise recoup overspending for all or part of the next calendar year, to recover in savings up to the amount of money overspent. To the extent possible, the

commissioner may reduce reimbursement rates or otherwise recoup overspending from individual providers who exceed the spending growth limits.

Subds. 2 to 2b. Renumbered 62J.35, subds. 1 to 3 in St.1993 Supp.

Subd. 3. Cost containment duties. After obtaining the advice and recommendations of the Minnesota health care commission, the commissioner shall:

(1) establish statewide and regional limits on growth in total health care spending under this section, monitor regional and statewide compliance with the spending limits, and take action to achieve compliance to the extent authorized by the legislature;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care system and working to achieve spending limits;

(3) provide technical assistance to regional coordinating boards;

(4) monitor the quality of health care throughout the state, conduct consumer satisfaction surveys, and take action as necessary to ensure in appropriate level of quality;

(5) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claim and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of

the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Health Care Financing Administration 1500 form, or other standardized forms or procedures;

(6) undertake health planning responsibilities as provided in section 62J.15;

(7) monitor and promote the development and implementation of practice parameters;

(8) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(9) designate referral centers for specialized and high-cost procedures and treatment and establish minimum standards and requirements for particular procedures or treatment;

(10) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health cm services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness program;

(11) administer the health care analysis unit; and

(12) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans.

Subd. 4. Consultation with the commission. When the law requires the commissioner of health to consult with the Minnesota health care commission when undertaking any of the duties required under this chapter and chapter 62N, the commissioner shall consult with the commission and obtain the commission's advice and recommendations. If the commissioner intends to depart from the commission's

recommendations, the commissioner shall inform the commission of the intended departure, provide a written explanation of the reasons for the departure, and give the commission an opportunity to comment on the intended departure. If, after receiving the commission's comment, the commissioner still intends to depart from the commission's recommendations, the commissioner shall notify each member of the legislative commission on health care access of the commissioner's intent to depart from the recommendations of the Minnesota health care commission. The notice to the legislative commission on health care seems must be provided at least ten days before the commissioner takes final action. If emergency action is necessary that does not allow the commissioner to obtain the advice and recommendations of the Minnesota health care commission or to provide advance notice. and an opportunity for comment as required in this subdivision, the commissioner shall provide a written notice and explanation to the Minnesota health care commission and the legislative commission on health care access at the earliest possible time.

Subd. 5. Appeals. A person aggrieved may appeal a decision made under this chapter through a contested case proceeding governed under chapter 14. The notice of appeal must be served on the commissioner within 30 days of receiving notice of the decision. The commissioner shall decide the contested case.

Subd. 6. Rulemaking. The commissioner shall adopt rules under chapter 14 to implement this chapter.

Subd. 7. Plan for controlling growth in spending. (a) By January 15, 1993, the Minnesota health care commission shall submit to the legislature and the governor for approval a plan, with as much detail as possible, for slowing the growth in health care spending to the growth rate identified by the commissioner, beginning July 1, 1993. The goal of the plan shall be to reduce the growth rate of health care spending,

adjusted for population changes, so that it declines by at least ten percent per year for each of the next five years. The plan may include tentative targets for reducing the growth in spending for consideration by the legislature.

(b) In developing the plan, the commission shall consider the advisability and feasibility of the following options, but is not obligated to incorporate them into the plan:

(1) data and methods that could be used to calculate regional and statewide spending limits and the various options for expressing spending limits, such as maximum percentage growth rates or actuarially adjusted average per capita rates that reflect the demographics of the state or a region of the state;

(2) methods of adjusting spending limits to account for patients who are not Minnesota residents, to reflect care provided to a person outside the person's region, and to adjust for demographic changes over time;

(3) methods that could be used to monitor compliance with the limits;

(4) criteria for exempting spending on research and experimentation on new technologies and medical practices when setting or enforcing spending limits;

(5) methods that could be used to help providers, purchasers, consumers, and communities control spending growth;

(6) methods of identifying activities of consumers, providers, or purchasers that contribute to excessive growth in spending,

(7) methods of encouraging voluntary activities that will help keep spending within the limits;

(8) methods of consulting providers and obtaining their assistance and cooperation and safeguards that are necessary to protect providers from abrupt changes in revenues or practice requirements;

(9) methods of avoiding, preventing, or recovering spending in excess of the rate of growth identified by the commission;

(10) methods of depriving those who benefit financially from overspending of the benefit of overspending, including the option of recovering the amount of the excess spending from the greater provider community or from individual providers or groups of providers through targeted assessments;

(11) methods of reallocating health care resources among provider groups to correct existing inequities, reward desirable provider activities, discourage undesirable activities, or improve the quality, affordability, and accessibility of health care services;

(12) methods of imposing mandatory requirements relating to the delivery of health care, such as practice parameters, hospital admission protocols, 24-hour emergency care screening systems, or designated specialty providers;

(13) methods of preventing unfair health care practices that give a provider or group purchaser an unfair advantage or financial benefit or that significantly circumvent, subvert, or obstruct the goals of this chapter;

(14) methods of providing incentives through special spending allowances or other means to encourage and reward special projects to improve outcomes or quality of care; and

(15) the advisability or feasibility of a system of permanent, regional coordinating boards to ensure community involvement in activities to improve affordability, accessibility, and quality of health care in each region.

Subd. 8. Implementation plan. (a) The commissioner, in consultation with the commission, shall develop and submit to the legislature and the governor by January 15, 1994, a detailed implementation plan, including proposed rules and legislation, to implement the cost containment plan recommended by the commission as described in the summary

report of the commission issued on January 25, 1993, as further modified by Laws 1993, chapter 345. The goal of the implementation plan must be to allow integrated service networks to form beginning July 1, 1994, and to begin a phased-in implementation of in all-payer system over a two-year period beginning July 1, 1994.

(b) To ensure a wide range of choices for purchasers, consumers, and providers, the rules and legislation must encourage and facilitate the formation of locally controlled integrated service networks, in addition to networks sponsored by statewide health plan companies.

(c) Financial solvency, net worth, and reserve requirements for integrated service networks must facilitate the formation of new networks, including networks sponsored by providers, employers, community organizations, local governments, and other locally based organizations, while protecting enrollees from undue risk of financial insolvency. The rules and legislation shall authorize alternative financial solvency, net worth, and reserve requirements for networks sponsored by providers that are based on the operational capacity, facilities, personnel, and financial capability to provide the services that it has contracted to provide to enrollees during the term of the contract provided the requirements are based on sound actuarial financial, and accounting principles. The criteria for allowing integrated service networks and participating providers and health care providing entities to satisfy financial requirements through alternative means may authorize consideration of:

(1) the level of services to be provided by a provider relative to its existing service capacity;

(2) the provider's debt rating;

(3) certification by an independent consulting actuary;

(4) the availability of allocated or restricted funds;

(5) net worth;

(6) the availability of letters of credit;

(7) the taxing authority of the entity or governmental sponsor;

(8) net revenues;

(9) accounts receivable;

(10) the number of providers under contract;

(11) indebtedness; and

(12) other factors the commissioner may reasonably establish to measure the ability of the provider or health care providing entity to provide the level of services.

(d) The implementation plan may include a requirement that an integrated service network may not contract for management services with a separate entity unless:

(1) the contract complies with section 62D.19; and

(2) if the management contract exceeds five percent of gross revenues of the integrated service network, provisions requiring holdbacks or other risk-related provisions must be no more favorable to the separate entity under the management contract than comparable terms contained in any contract between the integrated service network and any health care providing entity or provider.

(e) The implementation plan must include technical assistance and financial assistance to promote the creation of locally controlled networks to serve rural areas and special populations. The commissioner and the commission shall consider including in the implementation plan the establishment of a management cooperative that will provide planning, organization, administration, billing, legal, and support services to integrated service networks that are members of the cooperative.

(f) The implementation plan must address problems of provider recruitment and retention in rural areas. Rules and legislation must be designed to improve the ability of rural communities to maintain an effective local delivery system.

(g) The implementation plan must include a method to create an option for health care providers and health care plans

who meet or fall below the limits set by the commissioner under section 62J.04 to obtain a waiver from the applicability of the all-payer rules.

(h) In developing the implementation plan, the commissioner and the commission shall consider medical malpractice liability in terms of an entity operating an integrated service network and possible medical malpractice committed by its employees and make recommendations on any statutory changes that may be necessary. The commissioner may also consider whether a network and its participating entities should be allowed to reallocate between themselves the risk of malpractice liability.

(i) The implementation plan must identify the entities to whom an integrated service network may provide health care services, and persons or methods through whom or which an integrated service network may offer or sell its services.

(j) The implementation plan may consider the obligations that an integrated service network should have to the comprehensive health association established under section 62E.10. If obligations are to be required of an integrated service network, the implementation plan may provide for a phase-in of the assessments under section 62E.11. The implementation plan should clearly specify the rights and duties of integrated service networks with respect to the comprehensive health association.

(k) In developing the implementation plan, the commissioner and the commission shall consider how enrollees should be protected in the event of the insolvency of a network, how prospective enrollees should be informed of the consequences to enrollees of an insolvency, and the form of the hold harmless clause that must be contained in every network enrollee contract.

(l) In developing the implementation plan, the commissioner and the commission shall consider the

liquidation, rehabilitation, and conservation procedures that would be appropriate for networks.

(m) The rules and legislation must include provisions authorizing integrated service networks to bear the risk of providing coverage either by retaining the risk or by transferring all or part of the risk by purchasing reinsurance or other appropriate methods.

(n) The implementation plan must recommend the solvency requirements appropriate for a network, including net worth and deposit requirements, any reduced or phased-in net worth or deposit requirements that might be appropriate for new networks, government-sponsored networks, networks that use accredited capitated providers, or that have other particular features that provide a rationale for adjusting the solvency requirements.

(o) The commissioner shall determine the possible relationships between providers and integrated service networks, including requirements for the contractual relationships that may be required in order to ensure flexible arrangements between integrated service networks and providers.

Laws 1992, c. 549, art. 1, § 3, eff. April 24, 1992. Amended by Laws 1993, c. 247, art. 1, §§ 1 to 6, eff. May 18,1993; Laws 1993, c. 345, art. 1, § 1, eff. May 25, 1993; Laws 1993, c. 345, art. 3, §§ 2 to 4, 18, eff. May 25, 1993; Laws 1993, c. 345, art. 5, §§ 7, 8, eff. May 25, 1993; Laws 1993, c. 345, art. 6, §§ 2, 3, eff. May 25, 1993.

62J.35. Data collection

Subdivision 1. Data collection by commissioner. For purposes of forecasting rates of growth in health care spending and setting limits under section 62J.04, subdivisions 1 and 1a, the commissioner may collect from health care providers data on patient revenues and health care spending received during a time period specified by the commissioner. The commissioner may also collect data on health care revenues and spending from group purchasers of health care. Health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the forma specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.

Subd. 2. Failure to provide data. The intentional failure to provide the data requested under this chapter is grounds for revocation of a license or other disciplinary or regulatory action against a regulated provider. The commissioner may assess a fine against a provider who refuses to provide data required by the commissioner. If a provider refuses to provide the data required, the commissioner may obtain a court order requiring the provider to produce documents and allowing the commissioner to inspect the records of the provider for purposes of obtaining the data required.

Subd. 3. Data privacy. All data received under this section or under section 62J.37, 62J.38, 62J.41, or 62J.42 is private or nonpublic, as applicable except to the extent that it is given a different classification elsewhere in this chapter. The commissioner shall establish procedures and safeguards to

ensure that data released by the commissioner is in a form that does not identify specific patients, providers, employers, purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter.

Subdivision 4. Contracting. The commissioner may contract with private organizations to carry out the data collection initiatives required by this chapter. The commissioner shall require in the contract that organizations under contract adhere to the data privacy requirements established under this chapter and chapter 13.

Subd. 5. Rules. The commissioner shall adopt permanent rules and may adopt emergency rules to implement the data collection and reporting requirements in this chapter. The commissioner may combine all data reporting and collection requirements into a unified process so as to minimize duplication and administrative costs.

Laws 1993, c. 247, art. 1, § 1; Laws 1993, c. 345, art. 3, §§ 4, 8, 18, eff. May 25, 1993.

62J.38. Data from group purchasers

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for calendar years 1990, 1991, and 1992, and for calendar year 1993 and successive calendar years. Group purchasers shall submit data for the 1993 calendar year by February 15, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data, including raw data from claims, must be provided separately for the following categories: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures, and administrative costs.

(c) State agencies and all other group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

Laws 1993, c. 345, art. 3, § 10, eff. May 25, 1993.

62J.42 Quality, Utilization, and Outcome Data.

The commissioner shall also require group purchasers and health care providers to maintain and periodically report information on quality of care, utilization, and outcomes. The information must be provided at the times and in the form specified by the commissioner.

History: *1993 345 art 3 s 13*

62J.45. Data institute

Subdivision 1. Statement of purpose. It is the intention of the legislature to create a public-private mechanism for the collection of health care costs, quality, and outcome data, to the extent administratively efficient and effective. This integrated data system will provide clear, usable information on the cost, quality, and structure of health care services in Minnesota.

The health reform initiatives being implemented rely heavily on the availability of valid, objective data that currently are collected in many forms within the health care industry. Data collection needs cannot be efficiently met by undertaking separate data collection efforts.

The data institute created in this section will be a partnership between the commissioner of health and a board of directors representing health carriers and other group purchasers, health care providers, and consumers. These entities will work together to establish a centralized cost and quality data system that will be used by the public and private sectors. The data collection advisory committee and the practice parameter advisory committee shall provide assistance to the institute through the commissioner of health.

Subd. 2. Definitions. For purposes of this section, the following definitions apply.

(a) "Board" means the board of directors of the data institute.

(b) "Encounter level data" means data related to the utilization of health care services by, and the provision of health care services to individual patients, enrollees, or insureds, including claims data, abstracts of medical records, and data from patient interviews and patient surveys.

(c) "Health carrier" has the definition provided in section 62A.011, subdivision 2.

Subd. 3. Objectives of the data institute. The data institute shall:

(1) provide direction and coordination for public and private sector data collection efforts;

(2) establish a data system that electronically transmits, collects, archives, and provides users of data with the data necessary for their specific interests, in order to promote a high quality, cost-effective, consumer-responsive health care system;

(3) use and build upon existing data sources and quality measurement efforts, and improve upon these existing data sources and measurement efforts through the integration of data systems and the standardization of concepts, to the greatest extent possible;

(4) ensure that each segment of the health care industry can obtain data for appropriate purposes in a useful format and timely fashion;

(5) protect the privacy of individuals and minimize administrative costs; and

(6) develop a public/private information system to:

(i) make health care claims processing and financial settlement transactions more efficient;

(ii) provide an efficient, unobtrusive method for meeting the shared data needs of the state, consumers, employers, providers, and group purchasers;

(iii) provide the state, consumers, employers, providers, and group purchasers with information on the cost, appropriateness and effectiveness of health care, and wellness and cost containment strategies;

(iv) provide employers with the capacity to analyze benefit plans and work place health; and

(v) provide researchers and providers with the capacity to analyze clinical effectiveness.

The institute shall carry out these activities in accordance with the recommendations of the data collection plan developed by the data collection advisory committee, the Minnesota health care commission, and the commissioner of health, under subdivision 4.

Subd. 4. Data collection plan. The commissioner, in consultation with the board of the institute and the data collection advisory committee, shall develop and implement a plan that:

(1) provides data collection objectives, strategies, priorities, cost estimates, administrative and operational guidelines, and implementation timelines for the data institute; and

(2) identifies the encounter level data needed for the commissioner to carry out the duties assigned in this chapter.

The plan must take into consideration existing data sources and data sources that can easily be made uniform for linkages to other data sets.

This plan shall be prepared by October 31, 1993.

Subd. 5. Commissioner's duties. (a) The commissioner shall establish a public/private data institute in conjunction with health care providers, health carriers and other group purchasers, and consumers, to collect and proem encounter level data that are required to be submitted to the commissioner under this chapter. The commissioner shall not collect encounter level data from individual health care providers until standardized forms and procedures are available. The commissioner shall establish a board of directors comprised of members of the public and private sector to provide oversight for the administration and operation of the institute.

(b) Until the data institute is operational the commissioner may collect encounter level data required to be submitted under this chapter.

(c) The commissioner, with the advice of the board, shall establish policies for the disclosure of data to consumers, purchasers, providers, integrated service networks, and plans for their use in analysis to meet the goals of this chapter, as well as for the public disclosure of data to other interested parties. The disclosure policies shall ensure that consumers, purchasers, providers, integrated service networks, and plans have access to institute data for use in analysis to meet the goals of this chapter at the same time that data is provided to the data analysis unit in the department of health.

(d) The commissioner, with the advice of the board, may require those requesting data from the institute to contribute toward the cost of data collection through the payments of fees. Entities supplying data to the institute shall not be charged more than the actual transaction cost of providing the data requested.

(e) The commissioner may intervene in the direct operation of the institute, if this is necessary in the judgment of the commissioner to accomplish the institute's duties. If the commissioner intends to depart from the advice and recommendations of the board, the commissioner shall inform the board of the intended departure, provide the board with a written explanation of the reasons for the departure, and give the board the opportunity to comment on the departure.

Subd. 6. Board of directors. The institute is governed by a 20-member board of directors consisting of the following members:

(1) two representatives of hospitals, one appointed by the Minnesota Hospital Association and one appointed by the Metropolitan HealthCare Council, to reflect a mix of urban and rural institutions;

(2) four representatives of health carriers, two appointed by the Minnesota Council of Health Maintenance Organizations, one appointed by Blue Cross Blue Shield, and one appointed by the Insurance Federation of Minnesota;

(3) two consumer members, one appointed by the commissioner, and one appointed by the AFL-CIO as a labor union representative;

(4) five group purchaser representatives appointed by the Minnesota Consortium of Healthcare Purchasers to reflect a mix of urban and rural, large and small, and self-insured purchasers;

(5) two physicians appointed by the Minnesota Medical Association; to reflect a mix of urban and rural practitioners;

(6) one representative of teaching and research institutions, appointed jointly by the Mayo Foundation and the Minnesota Association of Public Teaching Hospitals;

(7) one nursing representative appointed by the Minnesota Nurses Association; and

(8) three representatives of state agencies, one member representing the department of employee relations, one member representing the department of human services, and one member representing the department of health.

Subd. 7. Terms; compensation; removal; and vacancies. The board is governed by section 15.0575.

Subd. 8. Staff. The board may hire an executive director. The executive director is not a state employee but is covered by section 3.736. The executive director may participate in the following plans for employees in the unclassified service: the state retirement plan, the state deferred compensation plan, and the health insurance and life insurance plans. The attorney general shall provide legal services to the board.

Subd. 9. Duties. The board shall provide assistance to the commissioner in developing and implementing a plan for the public/private information system. In addition, the board shall make recommendations to the commissioner on:

(1) the purpose of initiating a data collection initiatives;

(2) the expected benefit to the state from the initiatives;

(3) the methodology needed to ensure the validity of the initiative without creating an undue burden to providers and payors;

(4) the most appropriate method of collecting the necessary data; and

(5) the projected cost to the state, health care providers, health carriers, and other group purchasers to complete the initiative.

Subd. 10. Data collection. The commissioner, in consultation with the data institute board, may select a vendor to:

(1) collect the encounter level data required to be submitted by group purchasers under sections 62J.38 and 62J.42, state agencies under section 62J.40, and health care providers under sections 62J.41 and 62J.42, using, to the greatest extent possible, standardized forms and procedures;

(2) collect the encounter level data required for the initiatives of the health care analysis unit, under sections 62J.30 to 62J.34, using, to the greatest extent possible, standardized forms and procedures;

(3) process the data collected to ensure validity, consistency, accuracy, and completeness, and as appropriate, merge data collected from different sources;

(4) provide unaggregated, encounter level data to the health care analysis unit within the department of health; and

(5) carry out other duties assigned in this section.

Subd. 11. Use of data. (a) The board of the data institute with the advice of the data collection advisory committee and the practice parameter advisory committee through the commissioner, is responsible for establishing the methodology for the collection of the data and is responsible for providing direction on what data would be useful to the plans, providers, consumers, and purchasers.

(b) The health care analysis unit is responsible for the analysis of the data and the development and dissemination of reports.

(c) The commissioner, in consultation with the board, shall determine when and under what conditions data disclosure to group purchasers, health care providers, consumers, researchers, and other appropriate parties may occur to meet the state's goals. The commissioner may require users of data to contribute toward the cost of data collection through the payment of fees. The commissioner shall require users of data to maintain the data according to the data privacy provisions applicable to the data.

Subd. 12. Contracting. The commissioner, in consultation with the board, may contract with private sector entities to carry out the duties assigned in this section. The commissioner shall diligently seek to enter into contracts with private sector entities. Any contract must list the specific data to be collected and the methods to be used to collect and validate the data. Any contract must require the private sector entity to maintain the data collected according to the data privacy provisions applicable to the data.

Subd. 13. Data privacy. The board and the institute are subject to chapter 13.

Subd. 14. Standards for data release. The data institute shall adopt standards for the collection, by the institute, of data on costs, spending, quality, outcomes, and utilization. The data institute shall also adopt standards for the analysis and dissemination, by private sector entities, of data on costs, spending, quality, outcomes, and utilization provided to the private sector entities by the data institute. Both sets of standards must be consistent with data privacy requirements.

Subd. 15. Information clearinghouse. The commissioner shall coordinate the activities of the data institute with the activities of the information clearinghouse established in section 62J.33, subdivision 2.

Subd. 16. Federal and other grants. The commissioner, in collaboration with the board, shall seek federal funding and funding from private and other nonstate sources for the initiatives required by the board.

Laws 1993, c. 345, art. 3, § 15, eff. May 25,1993.

295.52. Taxes imposed

Subdivision 1. Hospital tax. A tax is imposed on each hospital equal to two percent of its gross revenues.

Subd. 1a. Surgical center tax. A tax is imposed on each surgical center equal to two percent of its gross revenues.

Subd. 1b. Pharmacy tax. A tax is imposed on each pharmacy equal to two percent of its gross revenues.

Subd. 2. Provider tax. A tax is imposed on each health care provider equal to two percent of its gross revenues.

Subd. 3. Wholesale drug distributor tax. A tax is imposed on each wholesale drug distributor equal to two percent of its gross revenues.

Subd. 4. Use tax; prescription drugs. A person that receives prescription drugs for resale or use in Minnesota, other than from a wholesale drug distributor that paid the tax under subdivision 3, is subject to a tax equal to two percent of the price paid. Liability for the tax is incurred when prescription drugs are received in Minnesota by the person.

Subd. 5. Volunteer ambulance services. Licensed ambulance services for which all the ambulance attendants are "volunteer ambulance attendants" as defined in section 144.8091, subdivision 2, are not subject to the tax under this section.

Laws 1992, c. 549, art. 9, § 7. Amended by Laws 1993, c. 345, art. 13, §§ 12, 13; Laws 1993, 1st Sp., c. 6, § 25.

295.53. Exemptions; special rules

Subdivision 1. Exemptions. The following payments are excluded from the grow revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.57:

(1) payments received for services provided under the Medicare programs including payments received from the government, and organizations governed by sections 1833 and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, and enrollee deductibles, coinsurance, and copayments, whether paid by the Individual or by insurer or other third party. Payments for services not covered by Medicare are taxable;

(2) medical assistance payments including payments received directly from the government or from a prepaid plan;

(3) payments received for home health care services;

(4) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (2), (7), (8), or (10);

(6) payments received from health care providers for goods and services on which liability for tax is imposed under sections 295.52 to 295.57 or the source of funds for the payment is exempt under clause (1), (2), (7), (8), or (10);

(6) amounts paid for prescription drugs, other than nutritional products, to a wholesale drug distributor reduced by reimbursements received for prescription drugs under clauses (1), (2), (7), and (8);

(7) payments received under the general assistance medical care program including payments received directly from the government or from a prepaid plan;

(8) payments received for providing services under the MinnesotaCare program including payments received directly from the government or from a prepaid plan and enrollee deductibles, coinsurance, and copayments;

(9) payments received by a resident health care provider or the wholly owned subsidiary of a resident health care provider for care provided outside Minnesota to a patient who is not domiciled in Minnesota;

(10) payments received from the chemical dependency fund under chapter 254B;

(11) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(12) payments received for providing patient services if the services are incidental to conducting medical research;

(13) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer,

(14) payments received for services provided by community residential mental health facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690, community support programs and family community support programs approved under Minnesota Rules, parts 9535.1700 to 9535.1760, and community mental health centers as defined in section 245.62, subdivision 2; and

(15) government payments received by a regional treatment center.

Subd. 2. Deductions for staff model health carriers. In addition to the exemptions allowed under subdivision 1, a staff model health carrier may deduct from its gross revenues for the year:

(1) amounts paid to hospitals, surgical centers, and health care providers that are not employees of the staff model health carrier for services on which liability for the tax is imposed under section 295.52;

(2) amounts added to reserves, if total reserves do not exceed 200 percent of the statutory net worth requirement, the calculation of which may be determined on a consolidated basis, taking into account the amounts held in reserve by affiliated staff model health carriers;

(3) assessments for the comprehensive health insurance plan under section 62E.11; and

(4) amounts spent for administration as reported as total administration to the department of health in the statement of revenues, expenses, and net worth pursuant to section 62D.08, subdivision 3, clause (a).

Subd. 3. Restriction on itemization. A hospital, surgical center, pharmacy, or health care provider must not separately state the tax obligation under section 295.52 on bills provided to individual patients.

Subd. 4. Deduction for research. (a) In addition to the exemptions allowed under subdivision 1, a hospital or health care provider which is exempt under section 501(c)(3) of the Internal Revenue Code of 1986[1] or is owned and operated under authority of a governmental unit, may deduct from its gross revenues subject to the hospital or health care provider taxes under sections 295.50 to 295.57 revenues equal to expenditures for allowable research program.

(b) For purposes of this subdivision, expenditures for allowable research program am the direct and general program costs for activities which are part of a formal program of medical and health care research approved by the governing body of the hospital or health care provider which also includes active solicitation of research funds from government and private sources. Any allowable research on humans or animals must be subject to review by appropriate regulatory committees operating in conformity with federal regulations such as an institutional review board or an institutional animal

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[1] 26 U.S.C.A. § 501(c)(3).

care and use committee. Costs of clinical research activities paid directly for the benefit of an individual patient are excluded from this exemption. Basic research in fields including biochemistry, molecular biology, and physiology are also included if such programs am subject to a peer review process.

(c) No deduction shall be allowed under this subdivision for any revenue received by the hospital or health care provider in the form of a grant, gift, or otherwise, whether from a government or nongovernment source, on which the tax liability under section 295.52 is not imposed or for which the tax liability under section 295.52 has been received from a third party as provided for in section 295.582.

(d) Effective beginning with calendar year 1995, the taxpayer shall not take the deduction under this section into account in determining estimated tax payments or the payment made with the annual return under section 295.55. The total deduction allowable to all taxpayers under this section for calendar years beginning after December 31, 1994, may not exceed $65,000,000. To implement this limit, each qualifying hospital and qualifying health care provider shall submit to the commissioner by March 15 its total expenditures qualifying for the deduction under this section for the previous calendar year. The commissioner shall sum the total expenditures of all taxpayers qualifying under this section for the calendar year. If the resulting amount exceeds $65,000,000, the commissioner shall allocate a part of the $65,000,000 deduction limit to each qualifying hospital and health care provider in proportion to its share of the total deductions. The commissioner shall pay a refund to each qualifying hospital or provider equal to its share of the deduction limit multiplied by two percent. The commissioner shall pay the refund no later than May 16 of the calendar year.

Subd. 5. Deductions for pharmacies. Pharmacies may deduct from their gross revenues subject to tax payments for

medical supplies, appliances, and devices that are exempt under subdivision 1, except payments under subdivision 1, clauses (3), (6), (9), (11), and (14).

Laws 1992, c. 549, art. 9, § 8. Amended by Laws 1993, c. 345, art. 13, §§ 14 to 17; Laws 1993, 1st Sp., c. 6, §§ 26, 27.

295.582. Authority

A hospital, surgical center, pharmacy, or health care provider that is subject to a tax under section 295.52 may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. The expense must not exceed two percent of the gross revenues received under the third-party contract, including copayments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 64B, or 62H, must pay the transferred expense in addition to any payments due under existing or future contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. Nothing in this subdivision limits the ability of a hospital, surgical center, pharmacy, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

Laws 1992, c. 549. art. 9, § 19. Amended by Laws 1993, c. 345, art. 13, § 22, eff. Jan. 1, 1993; Laws 1993, 1st Sp., c. 6, § 29.

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CHAPTER 4652

DEPARTMENT OF HEALTH

AGGREGATE GROUP PURCHASER DATA

4652.0010 INCORPORATIONS BY REFERENCE.
4652.0100 DEFINITIONS.
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4652.0010 INCORPORATIONS BY REFERENCE.

The ICD-9 diagnostic codes referenced in part 4652.0100, subparts 4 and 19, are contained in the fourth edition of the International Classification of Diseases, Clinical Modification, 9th Revision, 1994, and corresponding annual updates. This document is subject to annual revisions and is incorporated by reference. It is published by the United States Department of Health and Human Services, Health Care Financing Administration, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex interlibrary loan system.

The CPT codes referenced in part 4652.0100, subparts 4 and 19, are contained in the Physician's Current Procedural Terminology, (CPT manual) 4th edition, 1993. It is subject to frequent change. It is published by and may be purchased from the American Medical Association, Order Department: OP054193, P.O. Box 10950, Chicago, Illinois 60610. It is available through the Minitex interlibrary loan system.

Statutory Authority: *MS s 62J.35*

History: *19 SR 1515*

4652.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of chapter 4652, the terms in this part have the meanings given them.

Subp. 2. **Billing and enrollment expenses.** "Billing and enrollment expenses" means all costs associated with group and individual billing, member enrollment and premium

collection and reconciliation functions. Billing and enrollment expenses includes costs for the collection and reconciliation of cash, group and membership set-up and maintenance, contract, identification card, and directory preparation and issuance, electronic data interchange expenses pertaining to billing and enrollment, and enrollment materials. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to billing and enrollment expenses are: finance and information systems.

Subp. 3. **Charitable contributions expenses.** "Charitable contributions expenses" means all costs related to contributions made for charitable purposes.

Subp. 4. **Chemical dependency services expenses.** "Chemical dependency services expenses" means all costs related to inpatient and outpatient chemical dependency services that are coded using one or more of the following codes or amended equivalent codes:

A. ICD-9 diagnosis code ranges 303.00 to 305.92; and

B. CPT codes 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.

Chemical dependency services expenses also means all costs related to inpatient and outpatient chemical dependency services that are coded using codes from another coding system where the commissioner determines that the codes indicate diagnoses or procedures comparable to or consistent with codes listed in items A and B.

Subp. 5. **Claim processing expenses.** "Claim processing expenses" means all costs associated with the adjudication and adjustment of claims, coordination of benefits processing, maintenance of the claim system, printing of claim forms, claim quality assurance, electronic data interchange expenses pertaining to claim processing, and fraud investigation. Examples of traditional expense categories that a group

purchaser may allocate in whole or in part to claim processing expenses are: information systems and legal.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Health and authorized agents.

Subp. 7. **Customer service expenses.** "Customer service expenses" means all costs associated with individual, group, or provider support relating to membership, open enrollment, grievance resolution, claim problems, and specialized phone services and equipment. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to customer service expenses are: information systems, finance, legal, and sales and marketing.

Subp. 8. **Dental services expenses.** "Dental services expenses" means all professional and other costs provided under dental services contracts or riders.

Subp. 9. **Durable medical goods expenses.** "Durable medical goods expenses" means all costs for such items as wheel chairs, eyeglasses, hearing aids, surgical appliances, bulk and cylinder oxygen, equipment rental, and other devices or equipment that can withstand repeated use.

Subp. 10. **Emergency services expenses.** "Emergency services expenses" means all costs for medical care provided in the emergency room of a hospital.

Subp. 11. **General administration expenses.** "General administration expenses" means all costs not attributed or allocated to the categories of billing and enrollment, claim processing, customer service, product management and marketing, regulatory compliance and government relations, provider relations and contracting, quality assurance and utilization management, wellness and health education, research and product development, and charitable contributions. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to general administration expenses are: human resources, facility

maintenance, payroll, general accounting, finance, executive, internal audit, treasury, actuarial, finance, information systems, office management and occupancy costs, general office supplies and equipment, legal, board, outside consulting services, membership fees in trade organizations, public relations, and mail room. General administration expenses does not include taxes and assessments.

Subp. 12. **Group purchaser.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the costs of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. Group purchaser includes, but is not limited to, integrated service networks; community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Subp. 13. **Home health care expenses.** "Home health care expenses" means all costs for medical care services delivered in the home under the direction of a physician.

Subp. 14. **Inpatient hospital services expenses.** "Inpatient hospital services expenses" means all costs for those services furnished by a hospital for inpatient services, including hospice care. Inpatient hospital services expenses does not

include costs of mental health services and chemical dependency services.

Subp. 15. **Insurance company.** "Insurance company" means an organization licensed under Minnesota Statutes, chapter 60A, to offer, sell, or issue a policy of accident and sickness insurance as defined in Minnesota Statutes, section 62A.01.

Subp. 16. **Member.** "Member" means a person who has been enrolled as a subscriber or an eligible dependent of a subscriber for whom the group purchaser has accepted the responsibility for the provision of basic health services under a contract.

Subp. 17. **Member liability.** "Member liability" means the total amount payable by the member for health care services. Member liability includes deductibles, coinsurance, copayments, and amounts beyond plan maximums.

Subp. 18. **Member month.** "Member month" means the equivalent to one member for whom the group purchaser has recognized premium revenue for one month.

Subp. 19. **Mental health services expenses.** "Mental health services expenses" means all costs related to inpatient and outpatient mental health services that are coded using one or more of the following codes or amended equivalent codes:

A. ICD-9 diagnosis code ranges 290 to 302.9 and 306 to 319; and

B. CPT codes: 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.

Mental health services expenses also means all costs related to inpatient and outpatient mental health services that are coded using codes from another coding system where the commissioner determines that the codes indicate diagnoses or procedures comparable to or consistent with codes listed in items A and B.

Subp. 20. **MinnesotaCare tax expenses.** "MinnesotaCare tax expenses" means all payments made for the MinnesotaCare tax under Minnesota Statutes, section 295.52.

Subp. 21. **Minnesota resident.** "Minnesota resident" means a person who is listed on the records of the group purchaser as a member having a zip code within Minnesota. The group purchaser may use subscriber records if it does not have separate records for each member.

Subp. 22. **Other health professional services expenses.** "Other health professional services expenses" means costs for all services provided by health professionals other than physicians and dentists, including chiropractors, therapists, social workers, nurse practitioners, and medical dental services. Other health professional services expenses does not include costs of mental health services and chemical dependency services.

Subp. 23. **Other taxes and assessments expenses.** "Other taxes and assessments expenses" means all payments or amounts payable to government agencies except for the MinnesotaCare tax under Minnesota Statutes, section 295.52. Other taxes and assessments expenses does not include fees or fines paid to government agencies.

Subp. 24. **Outpatient services expenses.** "Outpatient services expenses" means all costs for those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and for which there is not a room and board charge. Outpatient services expenses does not include costs of mental health services and chemical dependency services.

Subp. 25. **Pharmacy and other nondurable medical goods expenses.** "Pharmacy and other nondurable medical goods expenses" means all costs to provide pharmaceuticals and nonreusable supplies or pieces of equipment that are used to treat a health condition.

Subp. 26. **Physician services expenses.** "Physician services expenses" means costs for all services provided by or under the supervision of licensed medical doctors, doctors of osteopathy, and ophthalmologists. Physician services expenses does not include costs of mental health services and chemical dependency services.

Subp. 27. **Product management and marketing expenses.** "Product management and marketing expenses" means all costs associated with the management and marketing of current products, including costs relating to product promotion and advertising, sales, pricing, broker fees and commissions, internal commissions and commissions processing, marketing materials, account reporting, changes or additions to current products, and enrollee education regarding coverage. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to product management and marketing expenses are: information systems, underwriting, legal, finance, actuarial, public relations, and network, management.

Subp. 28. **Provider relations and contracting expenses.** "Provider relations and contracting expenses" means all costs associated with contract negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, and administration of provider capitations and settlements. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to provider relations and contracting expenses are: finance, legal, accounting, actuarial, and information systems.

Subp. 29. **Quality assurance and utilization management expenses.** "Quality assurance and utilization management expenses" means all costs associated with quality assurance, practice protocol development, utilization review, peer review, credentialing, outcomes analysis related to existing products, and other medical care evaluation activities.

Examples of traditional expense categories that a group purchaser may allocate in whole or in part to quality assurance and utilization management expenses are: information systems and legal.

Subp. 30. **Regulatory compliance and government relations expenses.** "Regulatory compliance and government relations expenses" means all costs associated with federal and state reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, and costs associated with the preparation and filing of all financial, utilization, statistical and quality reports, and administration of government programs. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to regulatory compliance and government relations expenses are: information systems, finance, actuarial, sales and marketing, underwriting, contract, legal, utilization management, quality assurance, and compliance.

Subp. 31. **Research and product development expenses.** "Research and product development expenses" means all costs associated with outcomes research, medical research programs, product design and development for products and programs not currently offered, major systems development, and integrated service network development. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to research and product development expenses are: actuarial, information systems, marketing, finance, underwriting, and wellness programs.

Subp. 32. **Skilled nursing facilities expenses.** "Skilled nursing facilities expenses" means all costs for those services furnished by a facility primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services. Skilled nursing facilities expenses does not include costs of mental health services and chemical dependency services.

Subp. 33. **Subscriber.** "Subscriber" means an individual, employee, or employee with dependents who has been enrolled with a group purchaser and for whom the group purchaser has accepted the responsibility for the provision of basic health services under a contract.

Subp. 34. **Total premium revenue.** "Total premium revenue" means all premiums charged on all health insurance policies written for Minnesota residents, including the change in unearned premium from the previous year, minus refunds based on experience.

Subp. 35. **Wellness and health education expenses.** "Wellness and health education expenses" means all costs associated with wellness and health promotion, disease prevention, member education and materials, provider education, and outreach services. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to wellness and health education expenses are: marketing, medical services, and printing.

Statutory Authority: *MS s 62J.35*

History: *19 SR 1515*

4652.0110 GROUP PURCHASER REPORTING.

Subpart 1. **Group purchasers must report; exceptions.** All group purchasers, except as noted in items A to D, shall file with the commissioner a financial and statistical report on forms provided or approved by the commissioner.

A. An insurance company, as defined in part 4652.0100, subpart 15, that collected less than $3,000,000 in total health premiums for Minnesota residents in the year prior to the year that the data is covering may file a short report in lieu of filing a report that meets the requirements of part 4652.0120. The short report must be in writing, must state that the group purchaser collected less than $3,000,000 in total health premiums for Minnesota residents in the year prior to the year that the data is covering, and must provide the total

number of members and subscribers covered at the end of the reporting period. For purposes of this item, "health premiums" means premiums for health and medical related coverages, excluding accidental death and dismemberment coverages, short-term disability coverages, long-term disability coverages, long-term care coverages, workers' compensation coverages, the medical component of automobile insurance coverages, and personal accident coverages.

B. A state agency that reports under Minnesota Statutes, section 62J.40, is not subject to the reporting requirements of chapter 4652.

C. An employee health plan offered by a self-insured employer or an employee organization is not subject to the reporting requirements of chapter 4652. However, those employee health plans are encouraged to comply with these reporting requirements.

D. A group purchaser is not subject to the reporting requirements of this chapter if the coverages the group purchaser writes are limited to one or more of the following: accidental death and dismemberment coverages, short-term disability coverages, long-term disability coverages, long-term care coverages, workers' compensation coverages, automobile insurance coverages, and personal accident coverages.

Subp. 2. **Date for filing; reporting period.** The group purchaser shall file its report on or before April 1 of each year. The report must contain data for the preceding calendar year.

Subp. 3. **Organizations operating more than one group purchaser.** Group purchasers that are affiliated may elect to file a combined report, if they have elected to meet a combined growth limit under Minnesota Statutes, section 62P.04. Affiliated group purchasers that file a combined report must include in the report the name of each affiliated group purchaser.

Subp. 4. **Extensions.** The commissioner shall grant a group purchaser an extension to file the report when the

commissioner determines that the group purchaser has shown reasonable cause. To apply for an extension, the group purchaser must provide the commissioner with a written request for an extension to file, specifying the reason or reasons for the requested extension, and the proposed date for filing the report. "Reasonable cause" means that the group purchaser can demonstrate that compliance with the reporting requirements imposes an unreasonable cost to the group purchaser, or that technical or unforeseen difficulties prevent compliance.

Statutory Authority: *MS s 62J.35*

History: *19 SR 1515*

4652.0120 CONTENTS OF REPORT.

The report filed by a group purchaser must meet the requirements of items A to G. The information for each item must pertain to health and medical related coverages, excluding accidental death and dismemberment coverages, short-term disability coverages, long-term disability coverages, long-term care coverages, workers' compensation coverages, the medical component of automobile insurance coverages, and personal accident coverages.

A. The report must include total premium revenue and other revenue. "Other revenue" means, and must be specifically itemized into, the categories of minimum premium plan revenue, administrative services fee revenue, utilization review fee revenue, and reinsurance assumed revenue. Each revenue category must separate Medicare, and non-Medicare amounts.

B. The report must include total expenses incurred by type of policy, including insured business, self-insured business, Medicare, medical assistance, and general assistance.

C. The report must include total expenses incurred by service category, including physician services, other health professional services, inpatient hospital services, outpatient

services, skilled nursing facilities, home health care, emergency services, pharmacy and other nondurable medical goods, durable medical goods, chemical dependency services and mental health services, dental services, and total indirect health care expenses. Each service category must be itemized by type of policy as specified in item B. For Medicare Supplement coverages and for coverages designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, the report may list total expenses rather than itemizing the expenses for these coverages by service category.

D. The report must include total member liability, or its actuarial estimate, for all covered persons.

E. The report must include total indirect health care expenses by the following categories: billing and enrollment; claim processing; customer service; product management and marketing; regulatory compliance and government relations; provider relations and contracting; quality assurance and utilization management; wellness and health education; research and product development; charitable contributions; general administration; MinnesotaCare taxes; and all other taxes and assessments. The information required for this report may be estimated from existing accounting methods with allocation to specific categories

F. The report must include the total number of members and subscribers, as of the end of the reporting period, by type of policy, including family policies and individual policies and member months for the reporting period. Member months must be totaled for the calendar year of the report. This information must be reported separately for medical and dental contracts. Group purchasers that do not maintain member information may submit actuarial estimates of total number of members covered under all health policies.

G. The report must include a statement that the revenue and expense amounts reported under items A and B reconcile to audited financial statements. A group purchaser that does more than 80 percent of its business in Minnesota shall reference the appropriate entries from its audited financial statements and shall do so either by using the audited financial statements for its entire health care business or by separating its experience for Minnesota residents. The group purchaser's choice of method must be consistent from year to year. A group purchaser that does 80 percent or less of its business in Minnesota shall have an actuary or financial officer certify that the amounts reported reconcile to the audited financial statement in a manner consistent with prior reporting years and shall include an accounting or actuarial memorandum describing the methods used to identify and separate Minnesota data.

Statutory Authority: *MS s 62J.35*

History: *19 SR 1515*

4652.0130 REVIEW OF REPORTS.

Subpart 1. **Record complete.** No report required by this chapter is considered to be filed until the commissioner has determined that the report is complete. "Complete" means that the report contains adequate and appropriate data for the commissioner to begin the review and is in a form determined to be acceptable by the commissioner according to chapter 4652.

Subp. 2. **Review by commissioner.** The commissioner shall review each report required by chapter 4652 in order to ascertain that the report is complete. If the report is found to be complete or if the commissioner has not notified the group purchaser within 60 days of receiving the report that the report is incomplete, then the report is deemed to be filed as of the day it was received.

Subp. 3. **Incomplete report.** A report determined by the commissioner to be incomplete must be returned to the group purchaser with a statement describing the report's deficiencies. The group purchaser must resubmit an amended report to the commissioner. If the report is resubmitted within 30 days and is determined to be complete by the commissioner, then it shall be deemed to be filed as of the day it was first received by the commissioner.

Subp. 4. **Amending reports.** If a group purchaser discovers a material error in its statements or calculations in any of its submitted reports ascertained by the commissioner to be complete, the group purchaser shall immediately inform the commissioner of the error and, within a reasonable time, submit a written amendment to the report. Submission of an amendment under this subpart does not affect the date of filing.

Subp. 5. **Error in reports.** If the commissioner discovers a material error in the statements or calculations in a report, the commissioner shall require the group purchaser to amend and resubmit the report by a date determined by the commissioner.

Statutory Authority: *MS s 62J.35*

History: *19 SR 1515*

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

PATRICK BOYLE, JAMES DAUGHERTY, THOMAS R. FRANTES, P. DAN GILBERT, CHARLES MALONEY, THOMAS MARTIN, ROBERT SCHWARTZBAUER, and GARY THADEN, as the Board of Trustees of the Twin City Pipe Trades Welfare Trust,

Plaintiffs,

vs.

DOROTHY McCLUNG, in her capacity as the Commissioner of the Minnesota Department of Revenue, MARLENE MARSCHALL, in her capacity as the Commissioner of the Minnesota Department of Health, NATALIE STEFFEN, in her capacity as the Commissioner of the Minnesota Department of Human Services and, NANCY DAGG, in her capacity as the Administrator of the Children's Health Plan Plus, a/k/a MinnesotaCare Plan,

Defendants.

Court File No.:
3-92-602

AFFIDAVIT
OF
DORINE A. PAULY

STATE OF MINNESOTA)
) SS.
COUNTY OF HENNEPIN)

I, Dorine A. Pauly, state and depose as follows:

1. I am a secretary with the law firm of Lindquist & Vennum, 4200 IDS Center, 80 South Eighth Street, Minneapolis, Minnesota 55402.

2. I have listened to a cassette tape recording of an April 2, 1992 hearing of the Minnesota Senate Committee on Taxes and Tax Laws which was provided to this office by the Legislative Library.

3. I have transcribed a portion of that committee hearing. Attached hereto as Exhibit A is a copy of that partial transcript.

s/s
Dorine A. Pauly

Subscribed and sworn to before
me this 12th day of November, 1992.

s/Melonee R. Ham
Notary Public

SENATE COMMITTEE ON TAXES AND TAX LAWS
(Partial Transcript)

APRIL 2, 1992

Senator Novak: Amendment A25? Then I have a question, my questions is: Can I speak in real terms here? People most effected by are who? This is Blue Cross Blue Shield, Delta Dental, and some other people, correct?

Senator Berglin: Mr. Chairman and Senator Novak, that is included in part of the A23 Amendment that's already been adopted. We're taking about the A25 Amendment now and that is the pass through Amendment. That is not the issue that you are raising!

Senator Benson: A25 is an effort that we've been working with providers and its been worked out in conjunction with at least some of the providers, I don't know all of them.

Senator Novak: Mr. Chairman, that is my question. My question is; we're bringing in new people who are going to pay more taxes under this Amendment, correct?

Mr. Chairman: No! That's been adopted. We're bring in A25, Senator Novak, is to make sure that the providers, in fact, the taxes that we previously adopted this evening, as well as those from the original bill. That's what the Amendment is saying. A23, the previous Amendment has been adopted which included the new tax proposals that came forth this evening.

Senator Novak: Well, some place along the line Mr. Chairman, the question that I wanted to ask, in which ever

Amendment it was in. . . on the A25 Amendment, line 18, "to the extent allowed under federal law" what I want to know is, does that exclude the self-insured from paying the tax that the others have to pay?

Senator Berglin: Mr. Chairman, Senator Novak - No!

Senator Novak: Mr. Chairman I'm being told otherwise and before we leave here tonight I'd like to have a little testimony and find out for sure.

Mr. Chairman: A23 Amendment included the taxation of self-insured.

Senator Novak: And the question Mr. Chairman is, does the language on line 18, page 1, of Amendment A25 leave open a hole big enough to drive a Mac truck through? that in the real world is going to exclude those people from paying? That's what I want to know?

Senator Berglin: Mr. Chairman and Senator Novak, the answer is No!

Senator Novak: Mr. Chairman, before the nights over lets get a little testimony on it.

Senator Reichgott: Mr. Chairman, could I ask a little further why you are saying no, while the other person is saying yes? Could you give me your position on that?

Senator Berglin: Mr. Chairman and Senator Reichgott, the language that is in this Amendment simply is indicating, as we have in other parts of this bill, that everything we're doing in this bill is in accordance with federal law.

Senator Reichgott: Mr. chairman, Mr. Scandrett, I think I had the same concern as Senator Novak had about this, some of the other folks affected by this Amendment feel self-insured are excluded. . . What is your opinion?

Michael Scandrett (Senate- Counsel): Mr. Chairman, Senator Reichgott, this Amendment would allow hospitals to pass this on equally to all third-party contracts, to the extent that if possible; if there is a regular difference of opinion on the rates, some of the federal laws should be interpreted in this state, but the intent of the authors and the people who have been working on the bill, was that this should be passed on equally and that there are no exemptions in the bill but that all third-parties (purchasers) should be sharing the path to equal.

Senator Reichgott: And that includes self-insureds?

Scandrett: That's the intention of the Amendment.